VA HEALTH CARE DELIVERY FACILITIES IN WESTERN PENNSYLVANIA

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

FIRST SESSION

APRIL 25, 1983

Printed for the use of the Committee on Veterans' Affairs

Serial 98-17

21-871 O

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1983

H761-25

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VA HEALTH CARE DELIVERY FACILITIES IN WESTERN PENNSYLVANIA

MONDAY, APRIL 25, 1983

House of Representatives,
Committee on Veterans Affairs,
Subcommittee on Hospitals and Health Care,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9 a.m., at the Highland Park Veterans' Administration facility, Pittsburgh, Pa., Hon. Robert Edgar (chairman of the subcommittee) presiding.

Present: Representatives Edgar, Evans, Kaptur, Mollohan, Penny, Staggers, Rowland, McEwen, and Bilirakis.

Also present: Representatives Murphy, Kolter, and Walgren.

OPENING STATEMENT OF CHAIRMAN EDGAR

Mr. Edgar. I would like to welcome all of you to the first in a series of six regional hearings. I have with me a number of Members of Congress from across the country who have come to look at health care facilities here. After an opening statement, I will call on my colleague, Bob McEwen, who is the ranking Republican on this subcommittee today, to give an opening comment.

I will call on anyone else from our membership here on the subcommittee for opening comments, and then we will proceed.

I want to apologize to everyone for the fact that my opening statement may be a bit long. This is the first in a series of six national hearings, we wanted to set the tone in this opening statement. I hope that you will understand that the nature of it focuses on some of the specific and unique problems here in the western Pennsylvania area.

The Subcommittee on Hospitals and Health Care has come to this area, and I wish to express my sincere gratitude to all those who participated in putting these hearings together.

This is the first of six such oversight hearings the subcommittee plans to conduct during the first session of the 98th Congress. In each of these oversight hearings, we will hear from the regional director of the VA medical region.

This morning, we will not receive testimony from the directors of each of the VA medical facilities involved inasmuch as we will be visiting these facilities this afternoon and throughout the day tomorrow.

It was not necessary for them to come here to testify when we would be visiting them and having the opportunity to see visually what their facilities are.

I would be remiss if I did not note the excellent attendance at this oversight hearing by members of both the Subcommittee on Hospitals and Health Care and the Congressmen whose districts are represented here in western Pennsylvania.

For the record, I would like to introduce each of the Members present this morning and participating in the hearing.

Let me begin, to my right, introducing Dr. Roy Rowland, a physician from Georgia.

Second, let me introduce Harley Staggers, Jr., of West Virginia, and son of the former Congressman Harley Staggers, Sr.

Third, let me introduce Michael Bilirakis of Florida, and a graduate of the University of Pittsburgh, also a person who is from the Pittsburgh area, it is good to have him back in the region and in the area.

Also we have, as I mentioned, Bob McEwen from Ohio, who is the ranking Republican on this subcommittee today.

To my left is Lane Evans of Illinois, a Vietnam-era veteran and one of the new Members of Congress.

Also, next to him, is Alan Mollohan of nearby West Virginia, and son of the former Congressman, Bob Mollohan.

Next to him is Tim Penny of Minnesota. Tim comes to this subcommittee with aggressive interest in people and human need.

Austin Murphy of Pennsylvania, who served on this committee during the 97th Congress is with us today as one of the area's regional representatives in Washington.

Doug Walgren is an active member of the Pennsylvania delegation and a friend who has worked very hard on the needs of the Pittsburgh area and its specific concerns of unemployment, and I have enjoyed working with Doug on a number of important issues for Pennsylvania.

And finally, Joe Kolter of Pennsylvania. Joe is also a new Member of Congress and actively interested not only in the needs of veterans, but in many of the concerns that we face here in Pennsylvania.

It is unusual for the subcommittee to get the participation in a hearing outside of the city of Washington to the extent that we have here this morning. I want each Member to know that I personally appreciate their attendance and participation.

The Honorable Dick Caliguiri, mayor of the city of Pittsburgh, and speaker of the Pennsylvania House of Representatives, the Honorable L. Leroy Irvis, were invited to attend the hearing, but unfortunately, they were unable to join us due to prior commitments.

This series of oversight hearings is particularly important at this time due to the crossroads that the VA health care delivery system faces over the next 5 to 6 years in providing quality and quantity medical services for eligible veterans.

In the five VA medical centers we will visit today and tomorrow, there has been allocated in the fiscal year some $161 million and 4,255 employees to provide health care to eligible veterans.

As of the end of fiscal year 1981, there were an estimated 837,490 veterans in the western Pennsylvania area covered by the five VA medical centers we intend to review on this visit. It is estimated by the end of fiscal year 1990 just 7 years from today, this figure will decline by 52,890, or a total of 784,600 veterans will live in this area, a reduction of 7 percent.

However, over the same period, the number of veterans 65 years of age or older will increase from 89,220 to over 204,430, an increase of 129 percent.

Nationwide, the VA has estimated that the demand placed on the medical system due to increasing numbers of aging veterans will triple in the next 10 years. By 1990 alone, more than one-half of all American men over the age of 65 will be veterans.

Looking at these projections for western Pennsylvania, it is clear that the demand in this area will far outstrip the national estimates.

Right now, due to the catastrophic unemployment rate in the area, more and more veterans are coming to the VA for the first time. These facts indicate that we not only have a present problem but a future problem in maintaining the quality and quantity of care.

The rapidly advancing age of veterans not only places a heavy demand on the VA for nursing home care, but also for hospital care resulting from acute episodes of chronic illness in other veterans. We must cope with the present demand, but most important, we must be prepared to accommodate the future demand of the system as well.

I am sure many of you are aware of some of the recent publicity resulting from the President's private sector survey on cost control. This survey was chaired by Mr. J. P. Grace and was comprised of corporate executives from the private sector.

Fortunately, this subcommittee obtained a preliminary copy of the so-called Grace Commission's report which in effect states serious consideration should be given to eliminating the VA. Let me quote one sentence from the letter transmitting the preliminary report to Chairman Grace.

> In with the general theme of the President and the Commission, we started conceptually with the premise that the VA could be disbanded and its functions transferred to other agencies of the U.S. Government.

Let me repeat that quotation:

> In with the general theme of the President and the Commission, we started conceptually with the premise that the VA could be disbanded and its functions transferred to other agencies of the U.S. Government.

I want to state to individual veterans, their families, and to veterans organizations that, where this kind of smoke exists, there has to be a fire. The corporate executives concerned with this report have a great deal of influence in the present administration.

The House Committee on Veterans' Affairs is, in my view, the most bipartisan committee in the U.S. Congress; and I feel confident when I tell you that in our view, the Grace report does not have a prayer.

Having said this, however, I do not believe that the veterans' organizations and individual veterans can sit back and do nothing. The VA's health care program and other benefit programs have been enacted by Congress as the will of a grateful nation for the sacrifices these veterans have endured in serving the armed services of the Nation. But apart from that, the American people as a whole have greatly benefited from the investment in VA services and facilities.

The VA medical budget for fiscal 1984 is approximately $8 billion. However, that figure only represents 2.5 percent of all national health care expenditures. At the same time, the VA has provided part of the training, through its affiliations with private medical community, for more than one-half of all of the health care professionals in the United States.

VA research has recently received two Nobel prizes in medicine. The medical research program has been responsible for finding a cure for tuberculosis, developing the cardiac pacemaker, as well as major breakthroughs in kidney transplants, cancer research, renal disease, hypertension, and psychiatry, to name only a few.

The VA is the Nation's largest health care provider with 172 strategically located hospitals and 226 outpatient clinics serving as primary backup to the Department of Defense's medical system in time of war or national emergency as well. The investment made in VA has more than returned its investment in kind.

Another reason for this hearing and the oversight visits to these five western Pennsylvania VA health care facilities is to learn, firsthand, the present condition of construction, maintenance, and repair. This will give us some idea on which to build a solid base to provide quality health care to eligible veterans in modern health care facilities. In this regard, there are several construction projects in the pipeline that will affect these five medical centers.

These are: First, a new laundry at the Highland Drive VA Medical Center costing an estimated $6.5 million; second, an outpatient addition at the University Drive VA Medical Center costing $25.2 million; third, an outpatient clinic addition at the Butler VA Medical Center costing an estimated $5 million; fourth, the relocation of the research and education facilities and expansion of the clinical laboratory at the Erie facility costing $5.3 million; and fifth, the construction of a centralized warehouse at Aspinwall and the modernization of the entire hospital plant, both costing an estimated $114.2 million.

Funds have been requested for the first two projects in the fiscal 1984 budget, and the remainder to come in following fiscal years.

In addition, last month, the Congress responded to disastrous unemployment rates across the country and approved the emergency jobs appropriations bill, H.R. 1718. The legislation earmarked $4.6 billion to stimulate employment throughout the United States.

I offered an amendment to that legislation, now law, which targeted and restored over $1 billion to be used for public works jobs, and which was targeted to assist specifically in areas of high unemployment.

The so-called Edgar amendment was designed to provide additional employment opportunities particularly to distressed industrial areas of the Northeast and Midwest. It does not take a crystal ball to realize that each of the areas we will be visiting over the next 2 days will qualify as high-density unemployment areas for job assistance through this targeted amendment.

Within the entire bill, $75 million is earmarked for jobs through maintenance and repair of VA medical facilities. All five of the VA hospitals we will visit should share in part of those job-producing funds.

Again, I would like to thank all of you for coming, for all of the Members for their time and energy, for all the witnesses and the time that they took to put together their statements. I now yield to my colleague, Mr. Bob McEwen, who is the ranking Republican today.

STATEMENT OF HON BOB McEWEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. McEWEN. Thank you, Mr. Chairman.

Briefly, while I do not wish to expand upon your comprehensive opening remarks, I would reemphasize just three quick points. First of all, to express again our gratitude and appreciation for the hospitality and logistical support from Congressman Walgren and Congressman Kolter and our good friend and former colleague on this committee, Austin Murphy.

Second, I would say that I appreciate your willingness to hold these regional hearings and in a format and context whereby we will not only hold public hearings but will have the onsite visitation and inspection of the facilities in order to better perform our functions as members of this committee.

Third, I would say that not only will we be concentrating on nursing care and hospital facilities, but an emphasis toward outpatient treatment and the demand that has far exceeded the capacity of the Veterans' Administration to staff and fund outpatient treatment centers for non-service-connected veterans.

And, then, finally, I cannot help but feel a kind of responsibility to respond briefly to the subcommittee report to the chairman of the task force that would someday make their report to the administration concerning ways to improve and streamline Government.

That Grace report, I believe, has been considered far more than it has deserved. It has been renounced by all administration and Members of Congress unanimously, and those of us who have cosponsored legislation to make the Veterans' Administration a Cabinet-level position, would certainly be disappointed if the veterans would be put through the wringer the senior citizens were put through during the social security discussion, under the fear and spectre that some day the Veterans' Administration would be discarded.

And so I think that we have effectively laid that to rest this morning, and I just trust that we all understand that that is the case.

I would finally conclude by saying, Mr. Chairman, again my appreciation for the manner in which these hearings are to be conducted for your willingness to make this extra effort on your part. And I believe the attendance here this morning is testimony to our appreciation to the leadership that you are providing this subcommittee.

Thank you very much.

Mr. EDGAR. Thank you very much.

Without objection, I would like to submit into the record a letter from K. Leroy Irvis, sharing his concern for veterans, and also apologizing for not being able to fit this hearing into his schedule.[1]

Mr. Edgar. I wonder if any Member from the Pennsylvania delegation has a comment that they would like to make at this time? Mr. Walgren.

Mr. Walgren. As a Member of Congress whose district surrounds the area in which this facility is physically located, I certainly want to welcome the other members from across the country to the Pittsburgh area.

I think it has been a long time since we have seen this much interest in veterans' facilities, and I think you all ought to be congratulated, and, of course, particularly the chairman, for focusing this effort. We hope there are lessons here for the National Veterans' Administration system.

The problems facing veterans' facilities are overwhelming and it is, I think, the best sign that I have seen yet that they will be given every consideration that all of you are here today.

So, if I could make an opening statement as part of the record, with that much of a welcome, I appreciate the chance to participate with you.

[The statement of Mr. Walgren appears on p. 75.]

Mr. Edgar. Thank you very much.

Are there any other opening statements that anyone would like to make? The Chair recognizes Mr. Austin Murphy.

Mr. Murphy. Thank you, Mr. Chairman. I just wanted to thank you, Bob, and thank and welcome all our colleagues from various parts of the country who have set aside their first 2 days of this week to work with you.

Inasmuch as I previously served with you on this subcommittee, and unfortunately will become one of those statistics you mentioned on page 3, at the end of this decade, I am, of course, grateful to you and the members for your efforts in laying the groundwork for the vital medical needs of my fellow veterans as we approach the end of this century and into the first part of the next century.

I commend you, Bob, and your committee because this type of planning is absolutely essential as our veteran population ages.

And I know that you and your present members will carry that word back to Washington, D.C., and not follow the advice of the Grace Commission, and instead continue with the great work that the VA has done for many, many years, and will do for many years in the future.

Thank you, Bob.

Mr. Edgar. Thank you very much for those statements.

I yield to Congressman Kolter.

Mr. Kolter. Thank you, Mr. Chairman.

You know, I am a freshman here, and I think that it is appropriate that the first public hearing I have attended is away from Washington, D.C., and is here in the Pittsburgh area.

I think it is important to note, Mr. Chairman, that I do have a son who is a medical doctor here in Allegheny County who is training at the University of Pittsburgh, spent a considerable amount of time at the Oakland Hospital which resulted in quite a few operations he performed.

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[1] See p. 75.

As a former veteran of the Pennsylvania General Assembly for 14 years, I had a considerable amount of interest in the problems of the veterans.

I hope to continue my interest and learn more about these problems so I can vote intelligently on behalf of our veterans here.

Thank you, Mr. Chairman.

Mr. **Edgar**. Thank you very much for that statement. I don't see any other additional comments.

Mr. Bilirakis, do you want to say anything coming back home?

Mr. **Bilirakis**. Well, I thank you, Mr. Chairman.

I can't improve, really, on the other comments, I, too, am a freshman Congressman from Florida. And this is my first hearing away from the Washington area, and it is just perfectly fitting, I think, that it is in the Pittsburgh area. It isn't completely a coincidence that I decided to make this one.

I am awfully glad to be here, It is a real thrill for me, to—yes, I am concerned the 500,000-plus constituents that I have in Florida, but there is a warm spot in my heart, too, for the veterans and for the people in this area.

Mr. **Edgar**. Thank you very much.

Our first witness will be Mr. Charles Paulk, regional director of the medical region 2 of the Veterans' Administration.

Mr. Paulk, if you would come to the witness table and bring your colleagues, and introduce them.

Mr. **Paulk**. Thank you very much.

Mr. **Edgar**. Let me welcome you here this morning, and thank you for preparing your testimony in advance. Your full text of your statement will be made a part of the hearing record. It would be appropriate if you would introduce those who are with you this morning, and give their titles, and then you can proceed as you see fit.

STATEMENT OF CHARLES PAULK, REGIONAL DIRECTOR, MID-ATLANTIC REGION 2, VETERANS' ADMINISTRATION, ACCOMPANIED BY THOMAS A. GIGLIOTTI, MEDICAL CENTER DIRECTOR, AND CARL COSSU, MEDICAL CENTER DIRECTOR

Mr. **Paulk**. Thank you, Mr. Chairman, members of the subcommittee. I am very pleased to have the opportunity to be here.

Mr. **Edgar**. Could you pull the microphone closer?

Mr. **Paulk**. And we certainly thank you for choosing region 2 and medical district 5 here in Pittsburgh to have your first hearing.

I would like to introduce my colleagues. On my left is Mr. Tom Gigliotti. He is the medical district director for medical district 5; and in addition, he is the director of the University Drive and Aspinwall Divisions.

On my right is Mr. Carl Cossu, our host for the hearings today. He is the director of this medical center here at Highland Drive.

As you mentioned, Mr. Chairman, western Pennsylvania has five medical centers: Pittsburgh-University Drive, including its Aspinwall extended-care division; Pittsburgh-Highland Drive; Altoona;

Butler; and Erie. In addition to the 28 counties in Pennsylvania, these medical centers, along with the one in Clarksburg, W. Va., form our medical district 5, which serves 66 counties in the tristate Ohio/Pennsylvania/West Virginia area. Therefore, my remarks will be in reference to medical district 5.

You pointed out, Mr. Chairman, that this district has an estimated 837,000 veterans. It is authorized currently at 2,392 hospital beds and 405 nursing home care beds. The district has a combined medical center employment ceiling of 4,261 full-time equivalent and a combined fiscal year 1983 budget of over $158 million.

So far during fiscal year 1983 the number of inpatients treated is 6.5 percent over planned levels for the Pennsylvania facilities and the number of outpatient visits is 11 percent over the planned levels.

Occupancy rates are averaging 81.5 percent with a few facilities over 90 percent. Service to female veterans represent about 1.5 percent of the fiscal year 1982 workload; however, an increase of 20 percent in inpatient admissions and 40 percent in outpatient visits of female veterans has been noted so far this year over last year's average monthly rate.

Agent orange examination requests appear to have leveled off. However, radiation exposure claims and examinations are expected to increase.

Planned projections for the medical district, developed as part of the medical district initiated planning process—I will refer to that as MEDIPP, the term we use within the Department—showed a 7-percent decline in the number of veterans but a major shift in over 65-age veterans from 11 to 26 percent by 1990. This means district planning must address the problems of aging veterans.

This includes redefining missions, converting under utilized acute care beds to extended care or nursing home care beds; improving ambulatory care and outpatient facilities at several centers; and initiating or improving other services to the elderly veterans. The first MEDIPP plan is now in the approval process within the agency.

These planning efforts may result in consolidation of certain programs and functions. Relocation of some outpatient functions, addition of alcohol detoxification services, and initiation of geriatric day-care programs are other proposals for cost containment and improved services that are being considered.

As you mentioned, Mr. Chairman, construction of a consolidated laundry to service the greater Pittsburgh area medical centers will further assist in controlling the costs.

More than $22 million of fire and safety, direct patient care, and patient support improvements are underway in this district or have recently been completed. Over $48 million of clinical improvements and outpatient/ambulatory care improvements are about to get under way or are programed for Clarksburg, Altoona, and University Drive. Approximately $30 million of environmental and patient privacy improvements are programed for Erie and Highland Drive. The district is in the preliminary planning stages for a total rejuvenation of the Aspinwall facility anticipated to cost $110 million to support its key role of serving the aging veterans.

Expenditures of $10.7 million in fiscal year 1983 and the proposed fiscal year 1984 budget for consolidation of laundry and warehousing will both limit cost and improve efficiency.

Therefore, if the 5-year agency construction plan for the district is fully implemented, more than $220 million would be expended in medical district 5 between 1983 and 1987. This kind of expenditure is necessary to provide for the influx of female veterans, the increasing needs of the aging veterans, and to maintain safe, economical, and adequate environments for all eligible veterans in this district.

Maintenance and repair is an ongoing requirement. More than $6.3 million has been allocated for fiscal year 1983 for maintenance and repair projects, and an additional $3.5 million has been recommended for distribution by means of the recently passed jobs bill.

As can be well appreciated when maintaining 25- to 60-year-old buildings, the cost is a major consideration. Significant funds are required just to maintain the status quo.

Resources for planned workload and the temporary workload condition being experienced are still adequate. Staffing overall is generally adequate to meet planned workload. However, the urban medical centers are experiencing staffing problems with registered nurses; specifically, we are talking about specialty physicians in addition to nurses and certain technologists.

While salaries are not competitive in certain technological categories, the main impediment appears to be the fringe benefits offered by non-VA health care providers. Often, non-VA health care providers are offering employees significant educational packages, and fully paid medical/hospital insurance with equal or better coverage than available through Federal plans.

Despite the ever-present demand for properly using scarce resources at more or less static funding levels, several programs and activities have improved our overall ability to meet patient-care needs. An example of such a program is the automated data processing program, ADP, which is scheduled for rapid implementation. University Drive and Altoona Medical Centers already have installed small operational computers for certain administrative and patient-care support functions.

All six medical centers have been reviewed and sized for computers to handle the core functions of pharmacy, medical administration, and laboratory. Tentative delivery of these computers should begin in January 1984 at Erie, with University Drive receiving a very large unit in April of 1984. And that has been upped from my written testimony, as I submitted, from July to April. The other facilities will be receiving their units within about 270 days from ordering.

Sharing agreements exist where financially advantageous or services are otherwise unavailable to the district. University Drive Medical Center is also serving at the request of the Department of Defense as the coordinating facility for the military/civilian contingency hospital system, and the close consortium effort of medical district 5 is promoting a steadily increased sharing effort between these six VA medical centers.

This concludes my statement, Mr. Chairman. I or my colleagues will be pleased to respond to any questions that you or members of the subcommittee may have.

[The statement of Mr. Paulk appears on p. 78.]

Mr. **EDGAR**. Thank you, Mr. Paulk. I appreciate your extensive and fine testimony this morning.

Before moving to questions, let me recognize Marcy Kaptur, a Member of Congress, who has joined us, this makes 12 Members of Congress present. There are probably more Members of Congress per square inch in this medical facility than ever before. We are all trying to get in the "Guinness Book of World Records," I think, for the number of people here.

But the participation just reflects, again, a concern that we have about veteran's medical facilities. I have several questions I would like to ask you, because your testimony, while comprehensive and good, does contradict some of the statements that have been made at the central office in Washington, particularly as they relates to the ability to recruit nurses.

We were assured that that problem had been solved, and we would like to get into that and some other issues.

Let me yield to my colleague from Ohio, Mr. McEwen, for the first question.

Mr. **McEWEN**. Thank you, Mr. Chairman, and Mr. Paulk. I have two brief questions.

First of all, I noticed one sentence in your testimony referring to agent orange requests having leveled off. Could you elaborate on that? What numbers are we talking about? Do we see a leveling off? When did they happen? And what would be your explanation?

Mr. **PAULK**. I would be able to respond to that if I could find my notes here.

Mr. **EDGAR**. If the gentleman would yield, also, if you could indicate in your answer to that question, whether it is leveling off in terms of health care and also leveling off in terms of use of the readjustment counseling centers. I think the gentleman from Ohio's specific question relates to the issue of agent orange in terms of medical care.

Mr. **PAULK**. District 5, for fiscal year 1982, had 1,138 examinations. Is that right? So far this fiscal year, through 6 months' activity, the five medical centers have conducted 496 examinations.

The best that we can estimate we will come out just about 1,000 or in that neighborhood of requested examinations as related to agent orange. That was what our reference——

Mr. **McEWEN**. Do you have any explanation for that?

Mr. **PAULK**. I beg your pardon?

Mr. **McEWEN**. Do you have any insight as to why that would be?

Mr. **PAULK**. No, sir, I certainly don't. In the Pittsburgh area, or in this medical district 5, I am really surprised that we have not had more agent orange exams.

As you know, in some areas of the country we have had up to 20,000 requests. As a matter of fact, so far since Public Law 97-72 was passed, we have examined 108,000 veterans in the United States since 1978.

Right now I am told by the central office elements—and this report does not come to the region, it is consolidated in the central office—that we are doing about 2,000 examination per month. Now, that is the average. So I just can't explain why the numbers are not higher here in the Pittsburgh area.

Mr. EDGAR. If the gentleman would yield on that question.

Do you have any information on services provided to atomic veterans? We have been confronted with that as an issue. Are you getting requests from veterans who were exposed to the nuclear testing in the early fifties?

Mr. GIGLIOTTI. We are starting to get them at the University Drive. That workload has not built up yet, but we anticipate with the new advent of it, that there will be a lot more in the region.

Mr. EDGAR. Thank you. I yield back to my colleague.

Mr. MCEWEN. Mr. Paulk, you mentioned about acquiring and retaining good employees, and you mentioned that the private sector offers educational packages, hospital insurance and increased compensation.

Of those three, are there any changes that you would make in the compensation package that you are able to offer employees of the medical centers? What would you improve over the other areas? Are salaries competitive or are they the most significant?

Mr. PAULK. Well, in the Pittsburgh area, we have increased our starting salaries to try to stay compatible with the private sector.

Just last year, our entrance salaries was increased. It has been my experience, Congressman, that some of the university hospitals are in a position, whether they be State or private, to offer to nurses free tuition for graduate education programs.

I know that we have passed a law that helps us in higher education for some of our nurses. This seems to be really important to the professionals, to have that opportunity. I would think probably that is the most important, in my opinion, the education.

Mr. MCEWEN. Thank you.

I have just 2 minutes remaining, and so I want to ask this additional question: The Committee on Veterans' Affairs recently sent a questionnaire to all the area medical centers. The response from the medical centers in this medical district indicated a specific increase in the need for additional resources to provide quality medical care to eligible veterans on an outpatient basis.

Would you comment on what you, as the regional director, intend to do to provide for this increased need for resources in western Pennsylvania?

Mr. PAULK. Well, our fiscal year 1984 target allowance did, in fact, provide for a 5-percent increase in all other costs, which includes the total cost for outpatient care. However, due to the workloads, as in my statement, we are exceeding that.

We plan to reprogram moneys that will become available to us to supplement the funding for our medical centers just as we have done this year.

We have been hit by a real increase in costs in drugs, especially in the treatment of oncology, oncology drugs. We have supplemented our pharmacy costs this fiscal year at those centers that are really having a problem.

We monitor it monthly, Congressman, we shift money quarterly where we can pick up some reprogram money within the agency, and this is how I plan on covering it in 1984.

Mr. **McEwen**. Are those recurring funds, or is this just——

Mr. **Paulk**. No, sir. They are generally nonrecurring funds. Now, the pharmacy increased costs that we just put out within the region, is recurring funds, yes.

Mr. **McEwen**. And what sort of figures are we talking about?

Mr. **Paulk**. Oh, mine was in excess of $1 million within my region that is going out now. I forget the exact amount.

For instance, here at Highland Drive, our supplemental is—I mean University Drive, I am sorry—$197,000 recurring to help cover his pharmacy cost.

Mr. **McEwen**. Thank you.

Mr. Chairman, if I could prevail upon your generosity just for one more quick question, and that is, a major concern of mine is that in all of these efforts that are performed by VA Administrators and the hospital directors and the Members of Congress and all the rest, that all of that service funnels down to a clerk in the receiving room that creates an atmosphere for the veteran when he comes to receive service. That then is a judgment formed on the entire Veterans' Administration.

As the regional director, have you undertaken any programs to upgrade or to educate or to, basically, just to educate those people who are often entry-level personnel as to the critical importance of their position?

Mr. **Paulk**. Yes, sir; not only as a regional director, but back when I was a hospital director, I was very active in that, because your statements are really true. There is no question about it. We did have attitudinal training. We still have it going on.

We refer to it as tiger training, where we get in and we really let the person look at themselves. We don't do that just at the level of the admission clerks, or the receptionist or the receiving clerks.

We involve the entire staff. It is most important to receive a person who has the anxiety of being ill, and if any of us and any of you have ever gone into a hospital, there is a certain amount of anxiety that I would have loved for someone to calm me down.

The information clerks, the admission clerks are in a position to set that patient at ease. I don't know of a hospital in my facilities, or our facilities, not mine, but within the region, that do not pay special attention to that.

Not just only with the admissions clerks. We are talking about the nurses, we are talking the professionals, the support personnel as well.

Mr. **McEwen**. Thank you very much.

Mr. **Paulk**. Yes, sir.

Mr. **Edgar**. Thank you.

Congressman Lane Evans?

Mr. **Evans**. My questions deal with your relationship in this area with the vet center. I guess my questions are kind of general. What has your relationship been with the Pittsburgh area vet centers, and what is your opinion about the program in general?

Mr. **Paulk**. Well, I think, Congressman, we have one of the finest outreach centers here. As you know, we have two, we have one in downtown Pittsburgh, and then I believe we have one—let's see, where is the other—Monroeville. I see the sign as I drive in from the airport.

We have changed the organization responsibility for the supervision and the line of authority over Outreach. It used to be under the regional director via the hospital director. That is not the case any more. It is directly under line of the central office element, the outreach program, as you probably know.

We furnish support services such as the administrative services to the Outreach centers, the supply of the personnel, the fiscal, whatever it takes.

I am utterly amazed at the activity of these outreach centers. I have visited the one in downtown Pittsburgh. I have not been to the newest one out at Monroeville. I plan to make that visit very soon.

There were patients in there; they seemed to be getting adequate counseling. I think it has just done a wonderful job. I think it was badly needed, and I am certainly glad to be a part of it. They have my full support, whatever I can do.

Mr. **Evans**. I take it, then, you favor the extension of the program beyond its current expiration date of September 1984?

Mr. **Paulk**. I think that as long as we have the demand that we have now, yes, it is a viable program. That is my opinion.

Mr. **Evans**. All right. Thank you very much.

Mr. **Edgar**. I would like to point out for all of those who are in the audience that my colleague, Lane Evans, has a bill introduced in Congress to extend the readjustment counseling centers for three additional years beyond their expiration date. This proposal was developed after extensive hearings in Washington, where the need and the value of these storefront centers had been outlined.

The feeling was that the issue was not going to go away, and we are anxious to hear from the next witness, who will, in fact, zero in on that issue.

My colleagues, we have a number of witnesses and a number of Members here who have questions. I want to yield to you if you have specific questions to ask at this time.

Mr. Bilirakis?

Mr. **Bilirakis**. Just one, Mr. Chairman, and I thank you for yielding.

I am concerned about the occupancy rate, sir. Your testimony indicates that in fiscal year 1983, the number of inpatients is 6.5 percent over planned levels, and 11 percent for outpatient visits over planned levels.

When were these levels planned? When was the plan made for these levels?

Mr. **Paulk**. Actually, the plan for 1983 was made in 1982, fiscal year 1982.

Mr. **Bilirakis**. 1982?

Mr. **Paulk**. Yes, sir. We have budget hearings with the district. The regional director meets with each district to formulate a plan, to listen to their grassroots planning on their plan in April. We had it in March this year, for 1984. So we are 1 year, a good year in advance, 1½ years in advance.

Mr. **Bilirakis**. I see. Well, we have heard testimony, and certainly read that many of the veterans' facilities are being somewhat taxed, if you will, by virtue of the recession, the fact that there are many veterans who ordinarily use conventional means for medical care, now they lose their medical insurance, and lost their jobs and whatnot.

Do you find much of this happening in this area? That is basically the bottom line of my question.

Mr. PAULK. No, sir, I really don't. I feel confident, Congressman, that if a person applies for hospitalization and needs hospitalization, he is admitted. I think this is borne out by the fact that of all the applicants received in this medical district, 94.8 percent receive care. Now, that is both outpatient and inpatient care. It runs as high as 99.1 percent at Erie, Pa.

So I have had no complaints of people requiring hospital-type treatment of not being admitted to the hospital. We have had beds available due to our high turnover rates in many of these hospitals. Maybe you have, I hope that you haven't, but it certainly hasn't gotten to me.

Mr. BILIRAKIS. Are you saying then, sir, that you don't think that any of these increases over planned levels, which seems to be a very high occupancy rate of 81.5 percent, with a few over 90 percent, that that is attributable to the recession in any way? Do you feel that——

Mr. PAULK. Oh, yes, in my opinion, it does, yes, sir.

Mr. BILIRAKIS. It does?

Mr. PAULK. Yes, sir. In my opinion, as you pointed out, I am sure many of our veterans have lost their third-party payer's insurance. I am doing a study right now to see how many new applicants we have had this year versus that did not apply, or did not receive service last year.

And it is a significant number.

Mr. BILIRAKIS. Significant, I see.

Mr. PAULK. My first run, I hate to give it to you, because it is so soft, I am not sure of it myself. I am back to the second run.

Mr. BILIRAKIS. Thank you, Mr. Paulk.

Thank you, Mr. Chairman.

Mr. EDGAR. Thank you.

Congressman Mollohan?

Mr. MOLLOHAN. Thank you, Mr. Chairman.

Mr. Paulk, in your strict capacity as regional director of this mid-Atlantic region, do you oversee the maintenance and repair budgets for the various medical centers?

Mr. PAULK. I have prioritized it, Congressman. We have a program in our facility section in central office that reacts to the needs of the hospital on the maintenance, M&R programs, as we refer to it.

I do get a shot at helping the private ones, which ones we think are the most urgent.

Mr. MOLLOHAN. Are you familiar with the M&R costs of the medical centers?

Mr. PAULK. Yes.

Mr. MOLLOHAN. Will you be able to give me a figure for the budget for all medical centers in your area under the fiscal year 1983 appropriation?

Mr. PAULK. M&R? Let's see if I have that.

Mr. MOLLOHAN. While you are looking, the Veterans' Administration Medical Center in Clarksburg comes under your region, does it not?

Mr. PAULK. Yes, sir.

Mr. MOLLOHAN. Could you also pull that one out for me, if you can find it?

Mr. PAULK. Yes, sir, I have Clarksburg right here. I can give you the planned 1984.

Mr. MOLLOHAN. I can't quite hear you.

Mr. PAULK. I can give you the planned 1984, which is about $2.447 million.

Mr. MOLLOHAN. I am sorry?

Mr. PAULK. For 1984, about $2.4 million.

Mr. MOLLOHAN. For Clarksburg?

Mr. PAULK. No, not for Clarksburg. I've got Clarksburg. We have right now, for minor construction, renovate fire sprinklers, that is an ongoing program for $167,000. We expect to complete that in July.

Mr. MOLLOHAN. Now, you are talking about this year?

Mr. PAULK. This year.

Mr. MOLLOHAN. That is under the regular 1983 appropriations?

Mr. PAULK. 1983 appropriations.

Mr. MOLLOHAN. What is the total figure?

Mr. PAULK. We only have one other, to renovate surgery, is $387,000. So, that would be a total of about $554,000.

Mr. MOLLOHAN. $554,000 under the regular 1983 appropriations for M&R. Clarksburg.

Mr. PAULK. Yes. Right.

Mr. MOLLOHAN. OK, now, you indicate in your testimony that there is an additional $3.5 million out of, I think it was, the $75 million in the jobs bill, the supplemental appropriation. It has been designated for this region for spending, for maintenance and repair; is that correct? Under the jobs bill, in addition to the 1983 appropriation?

Mr. PAULK. That was recommended. That has not been approved. It is still being massaged. It will come to Congress, but first it has to go the Administrator, then it will come to Congress.

Mr. MOLLOHAN. You are talking about under the jobs bill?

Mr. PAULK. Yes, sir.

Mr. MOLLOHAN. I am glad to catch you, then, while you are still on the deciding stage. I would like to sensitize you to the fact that, unfortunately, my State has 21 percent unemployment, the highest in the Nation. And to the extent that we have some maintenance and repair that we can do down in Clarksburg, we would certainly appreciate having that accelerated under the jobs bill.

And I think you are also under a targeting amendment, Chairman Edgar's amendment, and I was pleased to work hard with him to get that passed, and I just want to sensitize you to that fact; No. 1, we have the highest unemployment in the Nation; No. 2, I am quite certain that we have maintenance and repair down there in Clarksburg, and we would like to see a good proportion of that $3.5 million spent down there in Clarksburg, if you would give us consideration for that.

I would like to hear from you about that, and I will probably be writing you a letter to see how we are doing on that.

Mr. PAULK. Well, that will be fine, as soon as it clears the Administrator's office. I understand that under the jobs bill, that they must brief Congress, and at such time, then, it would come back to me and I will be glad to call you.

Mr. EDGAR. Well, the gentleman has a couple more minutes for additional questions. I think what the gentleman is stating, if I could clarify, is whether or not you will be an advocate on behalf of targeting those funds to the areas that need maintenance, which are, in fact, in the areas of highest unemployment.

It is one thing to commit a jobs bill to the Nation, and then put a shopping list of projects that happen to fall in areas that have very low unemployment, but we have great needs within the rehabilitation maintenance of veterans' facilities with these additional funds that were not anticipated for fiscal 1983 expenditure. It is important for the regional directors to understand that it was the intention of Congress that as you make the priority listing, that those funds be expended in areas of highest unemployment.

You have a particularly difficult problem in western Pennsylvania——

Mr. PAULK. Yes, sir.

Mr. EDGAR [continuing]. Because all of the hospitals are covered. My hope is that, while it is difficult to rank in that area, you recognize some of the unique needs and responsibilities, to target funds, to accelerate the construction phase and the maintenance phase of some of the projects, to at least provide some help of sharing those funds and creating some jobs.

I yield to the gentleman again, for 2 additional minutes.

Mr. MOLLOHAN. Thank you, Mr. Chairman.

Mr. Paulk, you indicate on page 3 of your testimony, the first full paragraph, that over $48 million of clinical improvements and outpatient/ambulatory care improvements are about to get under way or are programed for Clarksburg, Altoona, and University Drive.

Not to be too provincial here, but I would like to get a handle on the First District of West Virginia. How much of that $48 million is for clinical improvement down in Clarksburg?

Mr. PAULK. The major construction for Clarksburg right now is planned for——

Mr. MOLLOHAN. I cannot hear you.

Mr. PAULK. I am sorry. Let me get back by year here.

Mr. MOLLOHAN. I only have 2 minutes, and then I have a couple more questions.

Mr. PAULK. I did mention the renovation of the fire sprinklers and the need to renovate the surgery program. In addition to that, in 1985, we have a planned $20.9 million clinical addition and alterations.

Mr. MOLLOHAN. My question is specifically directed at $48 million of clinical improvements, and I assume that is for this fiscal year. How much of it is for Clarksburg?

Mr. PAULK. No, sir, that is not the fiscal year. That is for a total of five, I believe, didn't I make reference to the 5-year plan? Clarksburg, in fiscal year 1985, is programed for $20.9 million for a clinical addition; in 1986, $2.5 million for boiler plant replacement; in

1984, as far as 1988, we have planned $2.7 million to renovate wards.

Mr. **Mollohan**. Thank you, Mr. Paulk.

Now, I will be back in touch with you in writing to clarify that, because I think we are on opposite tracks here.

Mr. **Paulk**. Thank you very much.

Mr. **Mollohan**. Let me ask you, I am specifically interested in the relationship between the Pittsburgh area medical centers and the Clarksburg medical center. And to give me a better understanding of the relative needs and capacities, could you please be responsive to these questions?

How many doctors do you have up here full time?

Mr. **Paulk**. Sixty-nine full time appointments, Congressman.

Mr. **Mollohan**. How many are——

Mr. **Paulk**. At the University Drive facility.

Mr. **Mollohan**. And how many are part time at the University Drive facility?

Mr. **Paulk**. Thirty full time and the rest are part time.

Mr. **Mollohan**. And what is the average length of stay of your physicians?

Mr. **Gigliotti**. It is a rather difficult question to answer right off. What is the average length? We have some physicians that have been with us a number of years, and in certain scarce specialties, they tend to leave sooner.

Mr. **Mollohan**. You don't have that answer just right at your fingertips?

Mr. **Gigliotti**. No, sir.

Mr. **Mollohan**. Would you please submit that for the record, Mr. Chairman, if we could?

Mr. **Edgar**. We will ask that unanimous consent be given to submit additional questions to you, including the question that has been asked, for the record.

Mr. **Mollohan**. Thank you, Mr. Chairman, and I will submit them. Thank you.

[The information appears on p. 82.]

Mr. **Edgar**. Mr. Rowland?

Dr. **Rowland**. Thank you, Mr. Chairman.

To pursue the questioning that Congressman Bilirakis was involved in a few moments ago, about the increase in the number of inpatient and outpatient admissions, apparently related to the high unemployment rate, can you tell me if there has been an increase in the number of psychiatric conditions relative to this high unemployment rate?

Mr. **Cossu**. Dr. Rowland, we do have an increase in our inpatient workload for this fiscal year. And I am not sure we can relate all of that to the economic situation, but we have had an increase of about 10 percent.

Dr. **Rowland**. How about outpatient?

Mr. **Cossu**. No, sir. I have checked that. I do not see an increase in the outpatient workload.

Dr. **Rowland**. You do not believe, at this time, that the high unemployment rate may be contributing to an increased number of psychiatric inpatient/outpatient encounters?

Mr. **Cossu**. It could be. I am not sure.

Dr. ROWLAND. Thank you.

Thank you, Mr. Chairman.

Mr. EDGAR. Thank you. Are there additional questions?

I have some specific questions I would like to ask. At present, are there any beds in your region that are closed because of lack of nursing care? That is, lack of ability to get nurses to cover those beds?

Mr. PAULK. Yes, sir. There is one right here in Pittsburgh. University Drive. I believe it is 40 beds.

Mr. EDGAR. Why don't we ask the director of the hospital to respond to the question of the VA's ability to hire and retain nurses and whether or not any beds are closed because of the lack of ability to recruit those nurses?

Mr. GIGLIOTTI. Yes; at present, at University Drive, we are below approximately 22 nurse—RN positions that we are funded for and can fill. And that is due mainly to the recruiting. We now have one 40-bed ward which is closed primarily due to the nursing staff.

Mr. EDGAR. Could you describe for the committee why it is so difficult to hire and retain nurses in your facility?

Mr. GIGLIOTTI. Yes, sir. I think as was mentioned earlier, one of the difficulties in the Pittsburgh area, while we have had permission to raise the salaries to be competitive on the basic salaries, one of the problem areas that we face are in these fringe benefits, and when the fringe benefits are added, the total hospitalization, anywhere from $500 to $1,000 a year granted to educational benefits. We face a little more difficulty in the recruitment.

Mr. EDGAR. I am going to get back to both medical directors in a second, but I would like to go back to Mr. Paulk.

Mr. MCEWEN. Could you yield a minute?

Mr. EDGAR. I yield to the gentleman.

Mr. MCEWEN. Excuse me, but, Mr. Gigliotti, you mentioned that you had 22 authorized positions; is that correct?

Mr. GIGLIOTTI. That are vacant.

Mr. MCEWEN. That are available, and then you said that they are not—that you don't have 22. How many do you have?

Mr. GIGLIOTTI. I am sorry, sir. I said I had 22 vacancies, RN's.

Mr. MCEWEN. I understand.

Thank you.

Mr. MURPHY. Will the gentleman yield?

Mr. EDGAR. I yield to the gentleman.

Mr. MURPHY. Among your vacancies, Mr. Gigliotti, some hospitals are solving their problem with employing part-time nurses who work 2 or 3 days a week, RN's who are not as concerned with the benefits. Are you authorized to do that?

Mr. GIGLIOTTI. Yes; we have been authorized to hire part time, and we have made efforts to hire part times. We also have held a refresher course last year, trying to attract nurses who have been out of the work market for a while, and would like to come back.

Mr. MURPHY. I want to thank you two personally for the many courtesies your office and Mr. Cossu's office shows my district offices. Thank you.

Mr. GIGLIOTTI. Thank you, Congressman.

Mr. EDGAR. I have additional questions, but I yield to Congressman Tim Penny.

Mr. Penny. I thank you, Mr. Chairman.

I notice in your testimony that your number of inpatients increased 6.5 percent over the anticipated level of patients for fiscal year 1983. Do you have any in-house information that might demonstrate whether that is a result of the age of those patients, or whether it would be the result of economic conditions that brought them to the VA Center?

Mr. Paulk. I really can't answer that. I don't know where that demand is coming from.

Mr. Penny. The projected patient usage would have been based, I would guess, on the demographics and the age structures. So it might be safe to assume that a large part of that increased usage is a result of economic conditions.

Mr. Paulk. I didn't hear the last sentence.

Mr. Penny. I am speculating that it, perhaps, was economic conditions, because you are expecting usage would take into account the age of the population. What I am getting down to is we are finding in Minnesota that there is an increased usage, and it is almost strictly related to the state of the economy.

Mr. Paulk. Well, we had an increase in the number of the first-time applicants, I am told. I do not have that figure. Do you have it, Tom?

Mr. Gigliotti. I have it for University Drive. We have had an increase in first-time applicants from October to March this year, we have seen 1,027 first-time applicants, whereas all fiscal year last year, for the same period last year, we saw 750. So we are on the verge of doubling, and I think that has attracted some additional workload.

Mr. Penny. OK. That is the figure I was looking for. Thank you.

Mr. Edgar. Thank you.

You state in your testimony that there was a significant increase in the number of women veterans who are using the facilities; is that correct?

Mr. Paulk. There has been about a 20-percent increase in applications received.

Mr. Edgar. Why?

Mr. Paulk. Why? I don't know. I can't answer this.

Mr. Edgar. It would be helpful if you could find out, because we are interested in two questions, one is, how the VA responds to the unique needs of female patients, particularly relating to privacy, and also we were intrigued by the increased percentage of female veterans who are now beginning to utilize VA facilities.

If you could do some thinking about that and provide that information for the record, it would be very helpful.[1]

Mr. Paulk. Mr. Chairman, all of our facilities in medical district 5 have the capability of caring for female patients.

Mr. Edgar. Do you have the ability to provide private rooms for women so they can use the bathroom facilities and maintain privacy.

Mr. Paulk. No, not necessarily private, but they will be segregated, if I may use that word, into maybe a ward area. In most instances, we do have private rooms to care for them, but we do, I think, have some four-bedroom wards. In one of my facilities, we have an entire ward of female patients.

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[1] Retained in committee files.

Another thing I would like to point out, that in any future constructions or renovations, we certainly have this in mind, under the privacy, under the various constructions, that we are going to create more facilities for the female patients.

Mr. **Edgar**. It is quite humiliating for female veterans to have to have someone stand outside of a men's room and wait for them to take a bath or a shower or to use the facilities in a proper manner. I think that all of us ought to be cognizant of that.

Let me ask a couple of more specific questions. We are taking a little bit longer with the first panel than we will with additional panels. So those of you who are waiting, I don't think we will have any problem with our time commitments.

The American Legion recently had representatives visit the VA Medical Center in Altoona. Among their conclusions were that the areas of need were acute psychiatric and alcohol treatment.

Could you comment on their recommendation for additional psychiatric and alcohol treatment in the Altoona area?

Mr. **Paulk**. Yes, sir. In our MEDIPP plan, we do, and I did mention it in my testimony, that we were planning some additional detoxification, alcohol detoxification. Altoona is one. And Butler, I believe, being another. So, yes, we did recognize that need, and we do have it in our long-range MEDIPP planning to initiate as soon as we can.

We also identified at Erie that we need psychiatric support. Last year, we were able to fund a mental hygiene clinic for Erie, which we will take a look at tomorrow, while you are up there. They are just now activating it, we did get the funds for it.

Mr. **Edgar**. Very good.

One of the things you did not mention in your statement was the use of State veterans' homes and their potential contribution to the care of the aging veteran. This is particularly important as the committee finds that the provision of extended care by State facilities is the most economical care provided to veterans.

Could you comment for the committee on the value of State veterans' homes?

Mr. **Paulk**. In my opinion, they are very valuable. I have been associated with State homes most of my VA career, having one time served in Oklahoma, where at that time, we had four veterans' State homes, more than any other State at that time.

The two State homes that we have here are invaluable to us. The one at Altoona and the one at Erie. I wish that your you could have time go to Altoona and see that particular one. I understand you are going to Erie.

Mr. **Edgar**. We will be seeing the one in Erie tomorrow morning.

Mr. **Paulk**. Yes, sir.

They are invaluable to us. In my opinion, we should try to encourage States to participate in the State home, the State dom programs, State nursing home program. It has a tendency to keep the patient in his immediate locality, geographic location. I just can't speak too highly of them.

Mr. **Edgar**. Let me read for you a quote from a 1981, February 26, General Accounting Office document:

> The Veterans' Administration's facilities are becoming functionally obsolete. Many of its hospitals are structurally sound, but do not have enough room or the correct space configurations to accommodate modern medical equipment, outpatient facilities, and air-conditioning and duct work.
>
> Currently, about one-third of the VA's 172 hospitals have no air-conditioning in the patient quarters. Although the agency is taking a hard look at its medical facilities, it is not replacing or renovating them fast enough to upgrade them to the new, higher standards of hospital occupancy.

Our information indicates that the veterans' medical center in Butler, Pa., was built in 1938 by the Commonwealth of Pennsylvania, and was taken over early in World War II by the U.S. Army.

In 1946, this hospital was transferred to the Veterans' Administration. Originally it was taken over by the VA as a tuberculosis hospital, and later, the mission changed to that of a general medical and surgical hospital.

Can you provide us with some data on the VA's current plans to modernize this particular hospital, and any reaction that you have to the General Accounting Office statement, which I read?

Mr. PAULK. Well, I can tell you what we have planned for Butler. I am not sure I am qualified to comment on what the report said. I have to assume it is pretty correct. They generally are. We have about $1.035 million planned in construction for VAMC Butler.

And just for instance, it is to update some of the outmoded things that we have.

Mr. EDGAR. Are there any plans for a total replacement of that facility?

Mr. PAULK. No, sir, not that I know of. There is not.

Mr. EDGAR. In your opinion, and this is just your opinion, suppose we don't make a major effort at rehabilitiation and reconstruction of some of these facilities. Will we find ourselves in the year 1990 or the year 2000 with facilities that are functionally obsolete?

Mr. PAULK. Some, yes; maybe.

As you know, right after World War II, we assumed and took over some Army-controlled type hospitals that were built in 1943 with a 10-year life expectancy, 15-year life expectancy, and we are still in them.

A case in point is Richmond and Martinsburg. However, we are fast building replacement hospitals for those two hospitals.

Mr. EDGAR. Your "some, yes, maybe" comment is causing some stir in terms of the legal reference to that phrase. Just in reference to the time that we have, I would like to move to your two medical directors and ask one question of each.

Mr. PAULK. Sure.

Mr. EDGAR. If you were to list the three things that you are most proud of in your facilities, what would they be?

And would you please list for the committee the three things that you most need if you are going to provide quality health care as we move into the next 5 or 10 years?

What are the three things, if you were going to take us on a guided tour, you would want to say, "Look how great we are doing in these three areas." And what are the three things that you would want to show us that are urgent needs, that, in your opinion, should be met?

I am asking you to be as honest as possible and not fearful of whether or not this meets with the priorities set by the VA Central Office. It is important for us in the field to get honest appraisals from the medical directors.

Mr. Cossu?

Mr. Cossu. Thank you.

As the host director, I first would like to say I want to thank you for coming to western Pennsylvania, and particularly to this facility to hold these hearings, and I am real pleased to see the number of members of the committee present. And I certainly want to thank you.

The three things I am most proud of at this facility are one, the dedication of our staff. With the exception of our need for more nurses, I think we are fairly well-staffed in other areas, and I think the quality of that staff is outstanding, and I think all of us are very proud of it.

And I think today, as you tour the facility and see the kind of care that is being given, I think you, too, will be pleased with the dedication of our staff.

I am proud of the physical plant itself of this facility. It was opened in 1953, and I think the maintenance and repair facility has been excellent. We do have several major construction projects under way to meet the kinds of needs you were addressing.

We do now have in process a fire and safety project, valued at about $4 million, and we do have visiting us this week from central office some people from our engineering service to examine a planned second phase of the fire and safety project.

It involved renovation of wards estimated at $12 million. If that project is approved, and I am hopeful that it will be, I think this facility will be well-prepared to meet the 1990 anticipated needs of our veteran population.

And the third thing I am most proud of is the kind of ambience we have here. We are trying to improve our units to be quite pleasant and colorful. This is the environment. We are trying to improve the interior design, move away from institutional colors, make the facility more attractive, so that our patients, many of whom are long-term care, will be able to enjoy their stay here and make it as pleasant as possible, because many of our patients have multiple chronic illnesses. And this, too, you will see in your tour today.

In terms of our most pressing needs, first I would reemphasize the need for our nurses. We have projected a need, right now, for 93 additional FTE's for this facility.

We recognize, as the regional director has pointed out to you, that the difficulty we have in obtaining these nurses relates to the tuition reimbursement, and also the health care cost that is provided by the private sector at 100 percent.

That is, I think, the one major need. The other is our need to attract board-certified psychiatrists at our facility. We are having problems in recruiting these physicians, not necessarily retaining them, but in recruiting board-certified psychiatrists, board-eligible psychiatrists, particularly those that are American-born and American-trained.

And the other need, I think, is additional dollars to improve certain areas of our facility, the construction dollars, particularly the second phase of our fire and safety project.

That $12 million, would go a long ways to improving this facility and meeting the future needs that we anticipate we are going to require.

Mr. EDGAR. The $12 million, do you see that in the pipeline?

Mr. COSSU. Would you repeat that, sir?

Mr. EDGAR. Do you see the $12 million in your pipeline for phase II?

Mr. COSSU. Yes, sir.

Mr. EDGAR. Thank you.

Mr. COSSU. I think—we will know this week for sure—but I think it will be in the 1985 design, 1986 construction.

Mr. EDGAR. Very good.

Mr. Gigliotti?

Mr. GIGLIOTTI. Yes, sir. I think we are very proud of both the University Drive and the Aspinwall facility. And I think one of our greatest prides is the capability of the medical staff that we have here, and the support staff that can provide the type of tertiary, specialized programs that meet our role as a tertiary care hospital in the medical district, such as, open heart, hemodialysis, and many of the other specialized medical programs.

We are also very proud of our relationship with the University of Pittsburgh Medical School. Through this relationship we are really able to provide what we consider excellent quality of care in the Pittsburgh area.

Mr. EDGAR. You are affiliated only with that medical school? There is not a dual affiliation?

Mr. GIGLIOTTI. No, sir, just with the University Medical School. And we are all so proud of our facilities, that we are now moving ahead with the construction of the ambulatory care wing at University Drive. I want to review some of what we may look at, what are some of our needs. I think the operating dollars to meet some of the increased workloads in outpatient that we have reported to the——

Mr. EDGAR. Operation dollars, you said?

Mr. GIGLIOTTI. Yes, to meet some of the outpatient workload. In the area of construction, we see the need, as you have already mentioned, it is in a pipeline renovation of the Aspinwall Hospital.

Construction for the ambulatory care is now planned as a 2-story building and we do have in a pipeline and feel a need for the third floor, which would improve out operating rooms and intensive care units.

And I guess the third need, as we see it, are some additional resource—personnel in some of the scarce categories.

Mr. EDGAR. OK. Thank you very much.

Marcy, did you have a question?

Ms. KAPTUR. Thank you, gentleman.

I come from northwestern Ohio and we have an outpatient clinic there. I was wondering if one of you could summarize for me what you need for your outpatient facilities and what you consider your greatest needs to be?

In our particular area, we don't have maintenance and repair needs. Our facility is fairly new. However, it appears that we have staffing needs.

Mr. GIGLIOTTI. I am not sure I know what you mean. We have need for a physical construction here, and I think that is where we are going through the plan for an additional ambulatory care wing.

Some of the outlying medical district areas, we are going with new construction in ambulatory care, and did I understand you are asking about personnel needs?

Ms. KAPTUR. Well, in your outpatient clinics, what are the primary needs? If you would, please describe them in the same way that you have outlined a need for nurses, for example, in this facility. As you look at your outpatient facilities, what are the greatest needs there?

Mr. GIGLIOTTI. Well, since we are in a process, I guess, of building some new ones, from my own, would be just staffing, but maybe Mr. Cossu——

Mr. COSSU. May I respond as it relates to psychiatry?

The problem, I think in this district, that we have in meeting the psychiatric outpatient requirements of our veterans, is accessibility to that care. I think we alluded earlier to our plans to get an alcohol detox program at some of the outlaying areas in the district.

Our facility here really is the primary facility in the district to provide inpatient care, and also most of the outpatient care.

As Mr. Gigliotti alluded to, we do have a mental hygiene clinic in Erie. I think there is one also scheduled for Altoona, but that is a future need. Right now, the problem is getting the service and making it accessible to those patients in our district.

Now, we do have a satellite clinic, or a traveling clinic, sometimes we send our staff—and just this week, we are sending our staff into West Virginia to have—where our staff goes and meets with the problems, rather than them traveling here.

But that is the kind of problem we have, and I think it is a need we have to address, and we are addressing in our medical plan.

Mr. PAULK. If I may, it is not particularly in this medical district, but I think we also go over to Ohio about once a week out of Butler, and do a little examining over there in that area, in Youngstown, I guess you have heard of that.

Ms. KAPTUR. Yes.

Mr. PAULK. As a region, my satellite outpatient clinics that are located in some deplorable GSA buildings. The one in Newark is absolutely unacceptable at any level. The one in Philadelphia is just a little above that. You know, it is certainly not conducive to the type of care that we in the department of medicine and surgery would like to see happen.

Are you referring to the Canton Clinic?

Ms. KAPTUR. Well, my area is Toledo.

Mr. PAULK. Toledo. On the other hand, at Allentown, Pa., we have a very lovely clinic. It is fully equipped, fully staffed. We have just recently, within the last year, added audiology. But we have a couple of pretty bad locations for outpatients, and we are trying to do something about it. We are trying to find other locations for the things of that nature. The facility is my main problem.

Mr. EDGAR. If the gentleman would yield just for a comment.

As we all look at the future of veterans' health care facilities, I think the question that you ask is really an important one.

My reading of the financial situation over the next 10 to 15 years, it may be that only in those areas of really excessive imigration of population will there be an ability to put new hospitals in place.

And my vision of what the health care facilities will be is an acute care facility located fairly centrally, and then several, probably more than we presently have, ambulatory outreach clinics spread throughout the area to provide quality health care to people that is not in an acute setting.

These probably will be located next to community hospitals, so that they can share facilities.

The gentleman has indicated both in Newark and Philadelphia that sometimes in our rush to put these ambulatory care clinics together, we put them in GSA facilities as backfill, not necessarily facilities that have the space for the kind of sophisticated equipment that would really make ambulatory care facilities really work.

And then you raised the question, how do you staff them with qualified and quality people, and my hope is that as we look to that question, we will address it. My guess is that we would locate those facilities that are not near a major acute care facility, but are isolated and out in the region. If we would locate that as close to a medical school or a community medical hospital in a region, they could share facilities and that whole sharing relationship is going to have to be developed as we move into the future.

I know in the Far West they have fewer acute care hospitals and many more, not only ambulatory facilities, but kind of the old Pony Express system, where they actually send doctors out into the field and out into the region certain days during the week.

And I think that is an area we ought to explore in the future.

Are there additional questions? I know Dr. Rowland has one, Bob McEwen has one, Joe Kolter. I am going to ask that we try to keep these questions to 1 minute a piece, so that we can move to our next witness.

Dr. ROWLAND. Thank you very much, Mr. Chairman.

I believe you indicated that the problem with recruitment and retention of nurses relates to pay scale; is that right?

Mr. PAULK. Not right here. No, sir. We have adjusted our pay scale. We believe that the big difference is on the fringe benefits, health insurance, tuition, things of that nature.

Mr. COSSU. I think there is one problem that we do have in the pay scale, and that is recruitment of junior grade nurses, those that are recent graduates. We do have special authority to recruit at the higher level, but in the area of recruiting the junior nurse, junior grade nurse, we have some problems with that, at least at this facility.

Mr. EDGAR. All right. Thank you for your question.

Mr. Kolter?

Mr. KOLTER. Thank you, Mr. Chairman.

Mr. Paulk, I think it is important that I acknowledge with many thanks the courtesies and the cooperation we have received on the many inquiries we have made of the hospitals. However, some of the inquiries we made have not been concluded. Sometimes the problems seem insurmountable, the mountains some of these disabled veterans are climbing are so high that they reach out for help, and I, too, am reaching out for help.

I respectfully ask you this question: On some of these problems that we have, is it possible—how can we best address these problems?

Mr. Paulk. Well, I think, if I was in your position, I would call the director of that facility, or your staff, or someone, contact that facility direct. If it is facility specific. If it is a larger matter, certainly feel free for you or your staff to call my staff in Washington, in region 2. And we will jump on the problem and if it is an individual problem, is this what you are addressing?

Mr. Kolter. Precisely correct.

Mr. Paulk. And I expect that you will have an answer within 24 hours, that is my timetable. We love to do it by telephone, Congressman. We can do it more rapidly, you are coming directly to us. If you send us a letter, it is going to go through the whole chain of command, and we may not get it for 4 or 5 or 6 days.

So if you want a rapid response, I would first have you or your staff contact that facility direct, by telephone. If you don't get satisfaction or they can't resolve it, certainly call the mid-Atlantic region and I will assure you we will respond immediately.

Mr. Kolter. All right, thank you, Mr. Paulk.

Mr. Edgar. I yield to my colleague, Bob McEwen, for a final question.

Mr. McEwen. Mr. Paulk, I need a one-word answer to this: The Veterans' Administration has legislative authority to use premium pay for weekend duty in order to attract nurses. Do you make use of that authority?

Mr. Paulk. Yes, sir, we do, since we have the authority. Yes, we pay premium pay.

Mr. McEwen. On a regular basis?

Mr. Paulk. Yes, sir.

Mr. McEwen. Thank you very much.

Mr. Paulk. As far as I know. There may be somewhere in the country they are not using it, but we use it, yes, sir.

Mr. McEwen. Thank you.

Mr. Edgar. Thank you very much. We anticipate we will have further questions this afternoon as we tour the specific facilities. We are grateful for your willingness to sit for such a long time and listen to our questions.

Mr. Paulk. Mr. Chairman, I would just like to take this opportunity to thank you and the entire Congress for their support by the veterans—now, I am speaking as a veteran, I guess, as well as the regional director—and the Administration and their support.

It makes our heart warm to see how much you all support us by this wonderful turnout in Pittsburgh, and we appreciate your interest very much.

Mr. Edgar. Thank you very much.

Mr. Edgar. We will now hear from Dr. Wayne Hartman, the team leader of the Vietnam Veteran's Vet Center in Pittsburgh, Pa. Dr. Hartman is accompanied by several other persons.

Gentlemen, thank you for your patience and thank you for coming this morning. As you could tell from our questioning, we have a number of questions that we want to direct specifically to the regional director. We have had extensive hearings in Washington on the issue and the value of readjustment counseling centers.

We wanted to have high on our agenda this morning representatives from the Pittsburgh area vet centers, and we are really grateful to you for coming and preparing your statement.

Dr. Hartman, the full text of your statement will be made a part of the record. We would appreciate if you could summarize to the extent possible, and share your statement.

Would you also, before you begin, introduce your colleagues who are with you?

STATEMENT OF WAYNE HARTMAN, TEAM LEADER, VETERANS CENTER, PITTSBURGH, PA., ACCOMPANIED BY DAVID McPEAK AND ARTO WOODS

Mr. **Hartman**. Thank you, Mr. Chairman. With me today are two members of my staff, both counselors at the vet center. On my right, Mr. Arto Woods, and on my left, Mr. David McPeak.

I am very pleased to have the opportunity to discuss the provision of readjustment counseling to Vietnam veterans in this area.

Provision of these services began in this area with the opening of the Pittsburgh Vet Center in April of 1980. Since that time, this center has seen over 2,000 veterans and their families and has provided a range of psychological readjustment services.

With the expansion of the outreach program, a second location was established with the opening of a satellite vet center in Monroeville in December of 1981. This expansion also added vet centers in Harrisburg and Morgantown, W. Va., which has made services more available in some of the more rural areas of western Pennsylvania.

A further step in this direction came with the implementation in 1982 of the contract-fees program, which has made services available in smaller communities, such as Altoona, State College, New Castle, Erie, Wheeling, and Youngstown. While there have been some difficulties in launching the contract-fees program in terms of attracting qualified health service providers and the program remains less than ideal in its cost and the time requirements placed on the vet center staff, the program has partially achieved the goal of making these services available to all Vietnam era veterans, regardless of their location.

It has certainly been illuminating to witness the significant changes that have occurred in the past 3 years. We initially saw many veterans who were angry and disillusioned with the system that had sent them to war and then tried to forget them. They saw little hope, trusted virtually no one, suffered the pain of posttraumatic stress disorder in silence and isolation and, as a group, were fragmented and scattered. Many had not talked with anyone about their war experiences and, in fact, had gone to great lengths not to even think about them. Symptoms of posttraumatic stress disorder were frightening, debilitating and, for the most part, unheard of by the professional community from which a few of them had sought help.

In the span of only 3 years, there has been a remarkable change, both in the attitudes of the veterans themselves and in the society that tried to ignore them. An upsurge of interest in the Vietnam war, as well was research evidence that uncovered and explained the existence of posttraumatic stress disorder, and the DAV's efforts in pioneering the concept of a network of community-based, self-help centers for Vietnam veterans, all had a great impact in bringing about this change.

And the impact has indeed been great. We have watched dysfunctional men turn into productive citizens; seen a fragmented and isolated group turn into a powerful political force which has dramatically made itself felt and heard. We have seen local organizations of veterans spring up, such as in this area, the Vietnam Veterans, Inc., which has done a tremendous job in recapturing the sense of pride, comaraderie and accomplishment, which are essential elements of psychological recovery from a wartime experience.

Perhaps the most important and significant event, however, was the one that seemed initially impossible a short time ago, and that was the dedication of the National Memorial to Vietnam Veterans, and the national salute that preceded it.

While we have come through a period of change through which the outreach program itself has evolved and undergone refinement, there remains the task of reaching and serving thousands of veterans who still suffer, as well as continuing to provide for the additional needs of our current clients.

In directing my comments more specifically now to the western Pennsylvania area, and the Pittsburgh and Monroeville centers in particular, I can report to you that as of Friday, over 2,300 Vietnam-era veterans and their families have been seen, for a total of over 12,000 visits. For those veterans suffering from posttraumatic stress disorder, we have found group therapy to be very effective in reducing their symptoms and enhancing their interpersonal effectiveness. In addition, spouses and families of eligible veterans are also included in the treatment process. The centers offer wives' groups at various intervals, as well as ongoing marital and family counseling.

To date, program statistics indicate an overall average of 5.2 visits per veteran client. The total staff of seven for both centers, which include a team leader, four outreach specialists/counselors, and two clerical positions, currently see an average of 253 separate clients per month. The centers continue to attract new clients at the rate of an average of 85 veterans per month. As a point of comparison, the Pittsburgh Vet Center's workload has increased from about 1,800 veteran visits in fiscal year 1980 to 2,950 in 1981, to a little over 3,200 in 1982. In comparing our total budget for both centers, with that case workload, the centers are providing readjustment counseling services for an approximate cost of slightly under $25 per visit.

In short, Mr. Chairman, I believe that the vet centers in western Pennsylvania have played a vital role in helping to transform the plight of this area's Vietnam-era veterans into a much more positive and hopeful scenario than was the case 3 years ago. The centers continue to provide quality readjustment counseling services to veterans and their families and do so on an efficient and cost-effective basis. What remains to be done now is to assure that every veteran in the country that needs help, regardless of how geographically isolated, has access to these services and made aware of their availability.

That concludes my statement, Mr. Chairman. I and members of my staff will be happy to answer any question that you or other members of the subcommittee may have.

[The prepared statement of Dr. Hartman appears on p. 84.]

Mr. **EDGAR**. Thank you.

Dr. Hartman, I have been in Congress for 8½ years, and was part of the movement to establish the readjustment counseling centers. As a new Member of Congress back in 1975 and 1976, it came to our attention that Vietnam-era veterans in need were not going to the antiseptically clean VA hospital settings, but, in fact, might be better served if, in fact, we had storefront centers and shelters where they could feel much more comfortable to receive counseling.

I want to compliment you and your staff on your fine work over the last several years. I also want to compliment the whole vet center program, because I think it has served as an example of how, through just a limited number of Federal dollars, we can reach out and touch those veterans who, from their service in Vietnam are still experiencing readjustment problems, particularly posttraumatic stress disorder. Through the centers we can reach out to them not only for employment and education services, but also for quality health care services.

A lot is being done throughout the Nation in this area, and what we learned in Washington was that there was an increase in the number of people finding their way to the centers, because of the attitude change that has occurred over the last couple of years.

I had originally introduced a bill in early January to extend the centers for 1 additional year, and to include a major comprehensive study that goes beyond the Center for Policy Research Study to look at the need.

Congressman Dan Mica on our committee, at my urging, introduced a bill to extend it for 2 years, because we began to feel as though 1 year would not be not enough to do an adequate study.

Congressman Lane Evans, who is to my left, introduced a bill, which I am pleased to be a cosponsor of, adding the 2 years to the 1 year, and making a 3-year extension.

It is my hope that we will be able to see a 3-year commitment made to readjustment counseling centers that would include a major comprehensive study of the Vietnam veteran and the specific needs, both job related, education related, and health related, and include in that study the impact that the centers are having on providing services to human beings who were involved the Vietnam-era conflict.

I would like to yield at this time to my colleague, Lane Evans, for questioning.

Mr. **EVANS**. Mr. Chairman, I appreciate your cosponsoring my bill and the support of virtually everybody else on this committee, on both sides of the aisle, in cosponsoring that bill.

I guess two reasons that I asked for an extension of 3 years was, first, that I think just a 1-year or 2-year extension would affect the morale of the staff of the centers, the teams that really have to put out a lot of their energy and effort. If they are not assured that there is going to be a program beyond another year, they are going to maybe look elsewhere for employment.

Plus, the second reason is the credibility within the Vietnam veteran community. If they don't feel that Congress is standing by a program, is merely reauthorizing it for another year, that that would affect the credibility of the program within that community.

Would you have that same feeling or comments along that line?

Mr. **Hartman**. Yes, I would. I think the staff certainly would be more comfortable knowing that their jobs were secure. Also, I am sure that the veterans would be more secure. I think we have come to the point now that they see us as a stable entity and something that will be here for them. And I think they would be also a lot more secure if we were going to be around a while.

Mr. **Evans**. All right.

I would like to ask you a few questions about the contracting out of the services. One of the ideas behind the vet center program is that it is, to a great degree, peer counseling, a lot of Vietnam veterans themselves involved in the program.

I know we had problems in the cost effectiveness of counseling out—or of contrating out the counseling. Do we also lose some of that peer support that a veteran doesn't get, perhaps, from going to a counselor who might not be a veteran or Vietnam veteran? Do you feel it is also, besides the cost factor, a less effective program because of the loss of that peer counseling?

Mr. **Hartman**. Well, I think it varies from program to program, but basically, the problem has been that there is not a lot of experience among the mental health community with Vietnam veterans and posttraumatic stress disorder. That became very clear when we began the contracting out process, and it remains a problem now.

So, while they are providing very good quality mental health care, the experience level with Vietnam veterans is not as high as it could be.

Mr. **Evans**. Is there any special training workshops that we require the contracting-out counselors to go through?

Mr. **Hartman**. None that are required. We had one here last summer which a lot of them attended, and it turned out very well.

Mr. **Evans**. All right.

Now, you stated that the cost of providing readjustment counseling services to the vet center program was slightly under $25 per visit. How would you compare that cost with providing the same type of a service on a contract basis?

Mr. **Hartman**. I believe in this area the contracts have basically a figure of $45 per visit in most of the contracts.

Mr. **Evans**. So, in essence, we have better services provided cheaper by the private—by the vet centers as opposed to the private counselors?

Mr. **Hartman**. Well, I think the point is, though, that many of these contractors are in areas where the vet centers are not able to reach, although there are these problems, I do think they are serving a need.

Mr. EVANS. All right.

You also stated that the effect of the Vietnam Veterans' Memorial and the Salute to Vietnam Veterans has had kind of a therapeutic impact, which is good. Has the increased unemployment in this area also brought out a great deal of problems of unemployment aggravating, perhaps, posttraumatic stress disorder? What kinds of problems are you facing with unemployment being as large as it is in the veteran community?

Mr. HARTMAN. Well, unemployment has certainly increased in this area, and aside from that being a stressor in itself, and many times veterans are mostly concerned with the employment issue when they first come to us. It also does have the effect of adding to the potential for posttraumatic stress symptoms. And we see those coming out as well.

Mr. EVANS. All right.

Well, I just wanted to take this opportunity to salute all of you, and thank you for your service to this country. I know the teams put on many long hours and burn-out factor is high, and we appreciate each and every one of your efforts to help the Vietnam-era veterans.

Mr. HARTMAN. Thank you, Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman.

Mr. EDGAR. Mr. Woods or Mr. McPeak, would you like to comment at all on any of the questions that were raised, or any additional comments about the center?

Mr. WOODS. Since I put on my best suit, I would like to say something at this time. When we first started in 1979, there was a big question as to whether posttraumatic stress disorder or the delayed stress syndrome existed, and the question was with the Congress, it was with the American people, and it was with some veterans themselves.

But we found that the question has repeatedly been answered to the affirmative. It was answered yes, with the Iranian hostage situation. Just yesterday, Moorehead Kennedy spoke at the University of Pittsburgh graduation, and he talked about those victims being monitored continuously.

It has been answered yes with the skywalk collapse in Kansas City and with the MGM fire in Las Vegas, in which a number of those persons are still receiving continued psychological and psychiatric services.

We have only dealt with the tip of the iceberg, because when we first started, we had less of the extreme left type veteran, the down-and-out, do-or-die type of individual coming into my office.

Recently, we have become involved into a situation of not only dealing with those veterans but some of the professional veterans like attorneys, policemen, firemen; those persons saying it is OK to have posttraumatic stress disorder.

I would like to say, when you go back and deal with your colleagues, whether you deal with 1-year proposal by Chairman Edgar, the 2-year by Mr. Mica, or the 3-year by Mr. Evans, please relate to them that there is no chicanery, there are no tricks coming into play when we talk about the delayed stress syndrome relative to Vietnam veterans.

We are very appreciative of your efforts, and we wish that you would view these veterans as the "boy next door"—and I am sorry, because there were a number of women who served in Vietnam, also—but as the children next door, who willfully interrupted their lives trying to be patriotic to the land of the free and the home of the brave, who physically fought over in Vietnam, but who have comeback home and for whom the war is still not over.

Thank you.

Mr. **Edgar**. Thank you very much for that moving statement. Your suit looks very good, and I just want to say that we appreciate the honesty and sincerity of your comments. We will take them back with us.

Mr. McPeak?

Mr. **McPeak**. I would like to make a short comment. I was seeing a veteran on Thursday night. He is a war veteran that came to my groups for about a year, you know, a heavy combat veteran, and I am seeing him now about, what is going in the here and the now, not the war. He is basically over with.

Just as example of the different services we have, you know, he has also come down for marriage counseling and his wife came to support groups. I was seeing him for here and now stuff, and he told me that a couple of weeks, ago he went to Florida on a visit, and while he was there, he looked up the name of his best friend's parents in Florida, and went to see them, which was a very difficult thing for us to do, to come out and recognize how much we love these men that we fought with and died with, and to visit their parents.

This kind of thing was done, probably done, after World War II, it wasn't done after Vietnam, for a lot of reasons. But he went down, and with a lot of persistence. This is on his vacation, he only gets 1 week a year, but he went down and spent a day looking up the parents of his best friend in Florida—finally found them, and called them up. This was 15 years ago and he said that, "I was your son's best friend in Vietnam. Can I pay you a visit?" To his surprise, they were very happy to see him.

We assume that everybody hates us. Maybe that is why we act so defensive sometimes, but he went and, you know, spent some time with the parents, and the mother never knew how her son died, how her 19-year-old boy died in Vietnam.

This man, since he has come to our groups, was able to tell them about it. He is comfortable with it now, talked to them, you know, connected with these people.

The father would ask him—the father is a VFW member, World War II veteran, would say, you know, "What kind of a soldier was my son?" My veteran would tell him the different occasions that he saved the lives of other men, how much he loved them, what a good soldier he was.

And the father would just get prouder and prouder, and the mother got to, you know, would feel better about it, and they hugged each other when they left.

He came back, told me about it and said:

> You know, if I ever did anything right in my life, it was going to see those people. It was because of—the only way I am able to do that, I was able to do that was

because I came to the Vet Center and worked that stuff out down here with the guys.

Thank you.

Mr. **Edgar**. I appreciate your personal illustration and I think that all three of you have demonstrated in your testimony this morning the urgency and the necessity of this program at this point.

Are there additional questions from my colleagues to the right? I yield to my colleague.

Mr. **Mollohan**. Addressing anyone, have you looked at use of the facilities as a function of proximity to them? Let me ask you: I know we have an Outreach center in Morgantown, which is not in my district, but it is next door. And I guess the VA hospital in Clarksburg provides the service; is that correct?

Mr. **Hartman**. Right.

Mr. **Mollohan**. Other than that, Wheeling, for example, and Weirton, Parkersburg may have an outreach center, I am not sure. But have you looked at the use of the facilities as a function of distance from them, and what, if anything have you concluded from that?

Mr. **Hartman**. From our experience, I think we have typically served, most of our veterans have come from within the immediate Pittsburgh area, Allegheny County, Westmoreland, and some of the surrounding counties.

I think as we get further away from the centers, the likelihood is less of veterans traveling the distance to get to them. Other than that, we haven't done any kind of formal study on it, but I think that would be basically true.

Mr. **Mollohan**. So, your experience is really with this particular system up here, and you don't——

Mr. **Hartman**. Right.

Mr. **Mollohan** [continuing]. Know how we are served in areas of less——

Mr. **Hartman**. I know——

Mr. **Mollohan** [continuing]. Sparsely populated?

Mr. **Hartman**. I know that most of the vet centers were initially placed in high-density population areas, and it was with the expansion that came 2 years ago that more of the rural areas, such as Morgantown, Harrisburg, which are not all that rural, but are smaller than cities like Pittsburgh.

There are still a lot of areas that don't have anything within 100 mile or so radius. For example, the closest vet center to the west of us is Columbus; and Cleveland to the northwest; Buffalo to the north.

Mr. **Mollohan**. Thank you, Mr. Chairman.

Mr. **Edgar**. Thank you.

Any additional questions? Thank you very much for your outstanding testimony.

Mr. **Hartman**. Thank you very much.

Mr. **Edgar**. I would like to ask our next two witnesses to come to the table together. The first is Dr. Donald Leon, dean of the medical school, University of Pittsburgh; and also, Dr. Robert Coon, vice president of health service and dean of Marshall University, Huntington, W. Va.

Both of you come to the table at this time.

Gentlemen, we appreciate your patience, and your willingness to come and testify today. We are interested in the role of medical affiliation and its impact on the quality of health care within the Veterans' Administration. The full text of your statements will be made a part of the record.

We will start with Dr. Leon, if you would, again, by summarizing your testimony, and picking out for us the important aspects of your relationship with the VA. You may proceed as you see fit.

STATEMENTS OF DR. DONALD LEON, DEAN, MEDICAL SCHOOL, UNIVERSITY OF PITTSBURGH, PITTSBURGH, PA., AND ROBERT W. COON, VICE PRESIDENT FOR HEALTH SERVICE, AND DEAN, MARSHALL UNIVERSITY, HUNTINGTON, W. VA.

Dr. LEON. Mr. Edgar, thank you very much. It is indeed rare for a medical school dean to have the opportunity to testify before a congressional committee, and yet I think that I have a great deal to tell you, and perhaps some of it will be startling.

In many ways, the medical care available to veterans in the greater western Pennsylvania community is exemplary. Obviously, there are some deficiencies, and I will allude to them later. These could be improved were it not for the constraints related to Federal budget limitations, which I consider serious.

However, by way of explanation, let me point out in the beginning the programmatic context in which the University Drive Veterans' Administration Medical Center is situated.

First of all, it is a full-fledged university teaching hospital with all of the advantages which accrue from that status. The University of Pittsburgh School of Medicine stands as one of the acknowledged leaders in teaching, research and clinical service in the United States.

We have 700 full-time faculty, 1,400 volunteer faculty, 545 first professional degree medical students, 85 graduate students in the sciences basic to medicine, and 650 advanced physician trainees in various medical specialties.

Our overall budget is just short of $100 million per year, and our sponsored research budget is over $30 million. We are part of a university with national stature, a member of the prestigious Association of American Universities. As you know, this association is made up of the 50 leading universities in the United States.

In addition, our medical school is a member of the distinguished Medical School Consortium, the other members are Harvard, Yale, Columbia, Cornell, University of Pennsylvania, Duke, the University of Rochester, Case Western Reserve, the University of Chicago, Stanford, Johns Hopkins, and Vanderbilt.

Our medical school conducts virtually all of its education, patient care, and research in its own health science center, the University Health Center of Pittsburgh. I am the president of the University Health Center of Pittsburgh.

The members of the health center are Children's Hospital of Pittsburgh, the Eye and Ear Hospital, Magee Women's Hospital, the Montefiore Hospital Association of Western Pennsylvania, Presbyterian University Hospital, and the University of Pittsburgh with its six schools of the health sciences.

The VA medical center is an affiliated member of the health center, and it would be a full member if it were not for Federal regulations which prohibit that type of contractual relationship.

We have 2,800 beds, 14,000 employees, 100,000 inpatient visits per year, and over 1 million outpatient visits per year. We have an annual budget in excess of $450 million a year.

We have three adult general teaching hospitals affiliated with our medical school. Presbyterian University, the VA Medical Center and Montefiore. Our house staff and students are trained within these three institutions and rotate from service to service between these hospitals during the usual academic year. It is obvious from these relationships that the University Drive Veterans' Administration Medical Center is a major and integral part of our medical education, research and clinical care complex.

I believe that the veterans who reside in western Pennsylvania community have benefited from this relationship. Most importantly, you should realize that the vast majority of physicians who staff the University Drive Veterans' Hospital are members of the full-time faculty of the University of Pittsburgh School of Medicine.

Our relationship is somewhat unique in that these university hospital physicians may aspire to and achieve university tenure as tangible evidence of the integral relationship and value in which the medical school holds this affiliation.

House staff and medical students provide care and receive high-quality instruction at the VA hospital as well as other hospitals in the health center. As even more tangible evidence of the importance of our academic affiliation, Dr. Stanley Geyer, the chief of staff at the VA Hospital, is one of my assistant deans, in addition to being a full-time faculty member. He is also chairman of the medical schools' curriculum committee.

The University Drive VA Hospital, and the patients it serves, benefits from having its medical staff made up of high-quality academic physicians who have competed successfully for full-time faculty appointments in one of the outstanding medical schools in the country.

The house staff and students have similar intellectual and professional strength.

As a result of the expertise of the staff-faculty physicians, the hospital has become very highly regarded as a tertiary referral center for VA medical district 5, about which you will hear more later.

Our staff-faculty physicians have been supportive of and deeply involved in medical district 5 MEDIPP planning, which seeks to improve care and efficiency throughout this entire district.

Patients referred to University Drive Hospital also benefit from a free exchange of medical school faculty who are assigned elsewhere in the health center, but help with VA hospital care and teaching exercises. By this expertise, the 74 VA staff have been expanded many-fold.

It is obvious that the patients who are cared for in this environment enjoy access to the very finest medical specialists and physicians in training. In addition to this, the hospital, in recognition of its important role as a dean's committee Academic Medical Center, continues to provide expert management, strong nursing and patient care support services and excellent referral relationships with other hospital within the University Health Center.

Having heard these strengths, one would ask where the deficiencies might be. Let me try to express them in general terms.

It is obvious to all that the Federal budget constraints have developed over the past few years. During this very same period, the demand for medical expertise has escalated in this community.

The house staff and faculty physicians have taken on vastly expanded loads, not so much in terms of numbers of patients, but in terms of advancing complexity of illness.

This can be seen in a statistical review of the experiences of the highly specialized services, such as open heart surgery, renal dialysis, organ transplantation, psychiatry, and so forth.

The effects of Federal budget constraints have been felt in limitations in nursing and support staff and limited ability to expand house staff support to handle the increased severity of illness.

I consider this quite severe.

The VA Central Office has been good enough to identify our problems and has managed to help us whenever feasible, but frankly, their resources are limited and we still have needs for some important improvements in staffing and equipment to keep pace with the ever-increasing complexity of illness which we are currently experiencing.

It is obvious that the hospitals and the patients are not the only beneficiaries of the academic relationship. The school of medicine benefits as well by having top-quality training opportunities for students and house staff.

In addition, the affiliation offers the opportunity for us to expand our faculty through VA staff mechanisms and this has been very important for the school.

The dean's committee, which I chair personally, also holds responsibility for the hospital in which you are currently seated, the Highland Drive Hospital. As you know, this is a long-term neuropyschiatric unit which just now is beginning to develop strong academic affiliations in psychiatry with our medical school.

I believe that the medical school stands to benefit greatly, as do the hospital and the patients.

As a last comment, I would like to turn to the question of geriatric medicine. Mr. Walgren made some very profound statements Friday afternoon on our campus concerning the impact of geriatric care on cost and the provision of care in the next decade.

Gentlemen, it is my opinion that the Congress of the United States, in fact, the whole Federal administration, has no concept of the onslaught of expense that you are about to face over the next decade. To meet this need, much must be done soon.

I think that VA facilities do need to be upgraded. Geriatric care is resource-intensive. This will require more nurses, more practitioners other than physicians. The number of physicians trained in geriatric medicine are inadequate, and this must be corrected.

I believe the VA has an obligation to provide training opportunities in geriatrics, because veterans are already one of the most needy groups.

I want to impress on you as strongly as I can, that in my opinion, we are not preparing as a nation for what we are going to face in the next 10 years.

I express my gratitude for the opportunity of speaking with you, and I am available for questions.

[The statement of Dr. Leon appears on p. 90.]

Mr. **Edgar**. Thank you very much. We will move to questions as soon as we hear from Dr. Coon.

STATEMENT OF DR. ROBERT W. COON

Dr. **Coon**. Thank you very much, Mr. Chairman.

As dean of one of the five new State-supported medical schools developed with Veterans' Administration assistance—and incidentally, also as a member of the special medical advisory group—I am very appreciative of the opportunity of being here and presenting this statement.

In contrast to the remarks which you have just heard, we probably are the smallest medical school in the country, rely heavily on affiliations with the community hospitals, and look on our affiliated Veterans' Administration hospital as our primary teaching hospital.

I will not read my testimony, but rather will summarize its contents.

We are very proud in the changes in the Huntington Veterans' Administration Hospital. It has changed from what was hardly more than a domiciliary a few years ago to a small, active acute general hospital.

We believe we are fulfilling the intent of Congress in passing the legislation back in 1972.

Our needs are similar to those of the other small and so-called 541 schools, that is, the ones started with Veterans' Administration assistance. We need more resources. We had a small base from which to start, and we have needs for personnel and for operating budget.

We need the planned addition with additional beds which is currently on the drawing boards, but projected well in the future.

We, as well as the system as a while, badly need computerization of our facilities. I doubt that our needs and those of the other medical centers affiliated with our sister schools, can be met by reallocation from within the system. I believe Congress needs to recognize the special commitment to these developing and expanding hospitals affiliated with our schools by appropriation of specifically designated funds for these institutions.

Thank you very much. I would be happy to respond to questions.

[The statement of Dr. Coon appears on p. 96.]

Mr. **Edgar**. Thank you very much for your statements, which are very comprehensive. The full text of your statement will be made a part of the record, as well as your extemporaneous comments that you have made.

I have asked our colleague, Dr. Rowland, to begin the questioning.

Dr. **Rowland**. Thank you very much, Mr. Chairman.

And I wish to commend both of you gentlemen for being here. I know, as a physician, how difficult it is for you to get away. I compliment you on your testimony. It is apparent from your testimony that you feel that there is a mutual benefit that exists between the medical schools and the VA, and I find this to be true in the Medical College of Georgia in Augusta, when I was going to school there, two fine VA facilities that we had there.

Dr. Leon, on page 4 of your testimony, the obvious Federal budget constraints that have developed over the past few years. Is this unique only to the veterans' medical program, or is it applicable to the Federal support of health care in general, do you think?

Dr. Leon. I am sorry, sir, I have missed your point.

Dr. Rowland. All right, well, you spoke on page 4 of your testimony of the obvious Federal budget constraints that have developed over the past few years. Is this unique only to the veterans' medical program, or is this applicable to Federal support of health care programs in general?

Dr. Leon. The latter is certainly true. Anything that is going to happen to the Veterans' Administration is going to happen to medicare, and it will be the same for the entire population.

Mr. Walgren commented on Friday that medicare is only prepared to meet about 50 percent of the expenses of that group of the population. If those expenses happen to escalate five or sevenfold in the next decade, at present funding practices, there is no mechanism to meet these expenses or even a 20- or 30-percent increase.

So, the crisis exists for the entire system, not simply for the Veterans' Administration.

Dr. Rowland. OK.

Well, the committee realizes that the VA's health care delivery system budget has escalated less than the inflationary rate, while at the same time, the cost of delivery of health care in the private sector continues to escalate at, maybe, 17 to 20 percent per year.

Are you saying that the resources, including the funding of the VA health care delivery system must escalate comparably to that of the private sector in order for the VA to continue to provide quality care to eligible veterans?

Dr. Leon. The answer to that question, sir, is yes. But may I expand slightly? In this country, something like 9.5 or 10 percent of GNP is devoted to health care, and that represents an increase from something like 4 or 5 percent a decade ago.

And there is common complaint that health care is taking up a greater portion of the national budget, and of course, it is. But if one looks at other highly-developed nations around the world, 10 and 11 and 12 percent GNP devoted to health care is common, and perhaps the United States has been playing some catchup.

What we cannot predict is what the demands of society will place on us for the next decade. It may, in fact, be 14 or 15 percent across the entire world, at least in terms of highly developed countries. I hope not, but it may be.

I do now know a physician in this community or private provider or a Veterans' Administration medical center that is not making real efforts to try to control costs.

Technology is certainly one problem, and health care is labor-intensive and that is another problem, in terms of keeping pace with inflation and retaining qualified employees.

You have heard today about the need to provide our VA nurses with university educational benefits, because every other nurse in the city receives them, not only in the university hospitals but in all hospitals. Little inducements like this are very important and inexpensive.

Dr. **Rowland**. Mr. Chairman, I have just one other question for Dr. Leon, and then I will yield.

On page 6 of your statement, you make reference to the tertiary hospital referral system for medical district 5 as contemplated by MEDIPP. Would you explain to us just what is contemplated in this plan in this regard?

Dr. **Leon**. Well, sir, we are the primary university hospital in medical district 5. Our University Drive hospital is a tertiary acute care hospital. We do open heart surgery, we do high-level cancer treatment, we do heart, kidney and lung, pancreas and bowel transplantation.

We are the only university in the United States which does some of these things. In fact, the only university in the world. We have an enormous dialysis program. We are working in the biochemical aspects of psychiatric disease, and so sir, we are simply the advanced level hospital for this district to which critically ill veterans are referred. The other hospitals are community-type hospitals, if you can make that comparison, and our hospital at University Drive is the university hospital for district 5.

Dr. **Rowland**. Thank you very much.

Mr. Chairman, I will yield at this time if there is anyone else that wishes to ask questions of Dr. Leon.

Mr. **Edgar**. Thank you.

Mr. Bilirakis?

Mr. **Bilirakis**. Thank you, Mr. Chairman.

Doctors Leon and Coon, you have both set out very well, and I certainly appreciate it, the benefits to the veterans as well as to the medical schools of this relationship—hospitals with veterans' centers.

Do you know of any instances where either the medical school or the veterans' center would refuse to enter into this type of relationship where it is geographically feasible to do so? And why would they, if there are any instances, such instances?

Dr. **Leon**. Sir, I do not know of a single medical school in the country that has not taken advantage of a veterans' hospital affiliation when available. The reason is that it gives the school an enormous opportunity for faculty development, and training sites for your students. And those we all need.

I will tell you frankly, 3 years ago, when the Draconian cuts occurred in the VA health care budget, from which we have partially recovered, there were some medical schools seriously considering telling the Veterans' Administration to go take a walk, because the flow of resources was definitely from the medical school, and the private practice sector of the medical school faculty, into the care of veterans. For a short time the VA was not paying its own way.

That has all corrected itself, and I do not know of any stress in that situation now.

Mr. **Bilirakis**. OK. So, on the other side, you don't know of an instance where possibly, maybe, a veterans' facility may have refused the relationship?

Dr. **Coon**. I am not aware of any.

Mr. **Bilirakis**. OK.

Mr. **Edgar**. Mr. Bilirakis, there was an incident in Philadelphia where the VA hospital had dual affiliation, which was quite confusing, because both medical schools wanted a chief of staff and wanted an office, and it got very touchy for a time. That has been resolved as the leadership in the medical community in Philadelphia did begin to pull things around.

There are some examples where almost too many affiliations take place, and the egos of some of the doctors have been quite aggressive. I don't know of any medical school that has refused to participate. It is usually the other way around.

Mr. **Bilirakis**. I have personally seen the University of South Florida in Tampa working with the James Haley Veterans' Center, Veterans' Hospital, and it works awfully well. I have been very impressed with that.

I think you sort of answered my other question, sir; you mentioned that Congress and the Government has no concept of the enormous future costs in the next decade, and that we must prepare.

I guess my question to you is, and you may have answered it, basically in saying that we have got to devote a higher percentage of our gross national product to medical facilities.

But I was going to ask you how would you prepare? Put yourself into our shoes now, in terms of long-term planning.

Dr. **Leon**. Well, sir, my responsibility is as an educator and an investigator. So, my preparation is to train the health professionals to handle the physician problem which is going to exist, and try to do as much investigation on the biochemical aspects of the diseases that characterize the elderly, and also in the health care management, through subsidiary organizations.

I think the Veterans' Administration does have the responsibility to upgrade its facilities and provide what is really a personnel-intensive, resource-intensive mode of care for older people.

It may be more of the gross national product. I hope not.

Mr. **Bilirakis**. Thank you, Mr. Chairman.

Mr. **Edgar**. Thank you.

I yield to Mr. Staggers.

Mr. **Staggers**. Thank you, Mr. Chairman.

I would be remiss if I didn't welcome Dr. Coon to the hearing. Being a fellow West Virginian, I am sure I speak for Mr. Mollohan also. I would welcome both of you, although I do have a feeling for Dr. Coon.

We are very proud of the Marshall facilities. I would point out to the committee that we are facing 21 percent unemployment, and there were some hard choices that had to be made, and these types of facilities are under attack in a State such as ours, and we are fortunate, with Huntington, that we had the finance chairman from Huntington, also.

So those are the little political things I need to point out, also. But I think there is another point that needs to be made, and Dr. Coon, you do mention in your statement, it is on page 3, that even with some of this help, that to effectively meet our veterans' needs, we desperately need to increase personnel and operating support.

You go on further. I think that that is probably a general statement, and I would ask for your response. Do you need more than is currently allocated to you by the VA? Is that a pretty correct statement? Would you like to elaborate on that?

Dr. **Coon**. Our problem has been that as a hospital which was functioning at a relatively low level back in 1976, when we started, we did not have a very adequate base on which to build.

As we have expanded services and improved the quality and upgraded the staffing, it has required more funds than we have been able to steal away from Richmond and the other hospitals in the district.

I recognize that the appropriations for the VA have increased, but they have not kept pace with inflation. The pressures in these other centers have been very great, and additional funds which we received have been primarily by reallocation, which has thrown a stress on all the other hospitals within the district.

Mr. **Staggers**. Dr. Leon, I saw you shaking your head. I assume that you——

Dr. **Leon**. I thoroughly agree. Absolutely.

Mr. **Staggers**. The one other general question I have, and I am going to ask you an impossible question. You probably don't have an answer. I am hoping for a miracle, but it has been testified by several other people who have testified that there is a shortage of qualified people, there is budget cuts. Is there anything you can do without spending money?

Is there any way that educators and administrators, working together, can provide that incentive for qualified people to get there, other than the education package which I mentioned before, except for increasing pay or whatever?

Is there anything else we can do? Is it a budgetary matter? Or is there any other incentives we may be able to provide to attract——

Dr. **Coon**. Excuse me. I would agree that possibly the fringe benefits are a factor. In our situation, we do have at the VA hospital vacant positions. We do have beds that are closed because of inability to provide staffing.

Now, Huntington at the moment has an adequate supply of nurses. Nurses do not like to do work at the VA hospital, and I think it is for a couple of reasons. First of all, it is 8 miles from the center of town, and although that is not far in Pittsburgh, as I found out coming from the airport, it is a considerable distance.

The second thing is there is a certain aura of redtape and bureaucracy which makes it a seemingly oppressive place in which to work, from the point of view of many of the professionals.

I think we are overcoming that very definitely in our situation. We have improved it markedly since the VA hospital has really been made a part of the community in its efforts at looking at health care delivery and planning.

Mr. **Staggers**. Thank you.

Thank you, Mr. Chairman.

Mr. EDGAR. Thank you.

Are there any additional questions?

Mr. WALGREN. Mr. Chairman.

Mr. EDGAR. Congressman Walgren?

Mr. WALGREN. Focusing on the geriatric side, what would a good program in the VA look like in geriatric training, and have such proposals been made? Are we working on any in Pittsburgh? Where should we be going in that area?

Dr. COON. Doug, there have been opportunities from the central office for a limited number of geriatric training centers to be developed, and there are a round of them coming up just about now.

Mr. EDGAR. If the gentleman would yield.

Doug, there have been authorized 15 GRECS, or geriatric, research, education and clinical centers, by the VA central office. Only nine have been established.

Congresswoman Margaret Heckler from Massachusetts, who is now the Secretary of Health and Human Services, was a real advocate on our committee, and a few of us joined a few years ago to commit about $25 million of allocation to begin to establish the geriatric centers throughout the country.

My hope is that we can push for the establishment of all 15 research centers on geriatric medicine and then look at the need to expend those beyond, because one of the statistics that jumps out at us is that there are presently 3.3 million veterans who are age 65 or older.

In 7 years, we will have 7.6 million veterans at that age. So, we will double and triple that number over the next few years, of people who will need access to quality health care, particularly as aging veterans, and we need to go to the full 15 geriatric centers as quickly as possible.

Mr. WALGREN. And if I might ask, where does the Pittsburgh center fit in that program?

Dr. LEON. We are applying, at the present time, for a new center grant. We want to use our Aspinwall facility in combination with this hospital for its special neuropsychiatric emphasis.

We are very optimistic. We have a strong geriatric program in the medical school on the private side of the street.

Mr. WALGREN. Do you see the program that is potentially going to be developed in these centers as having the proper components to it?

Dr. LEON. I think so, yes. I am satisfied with the conceptual design.

Mr. WALGREN. Thank you, Mr. Chairman.

Mr. EDGAR. Thank you.

I yield to my colleague, Bob McEwen.

Mr. MCEWEN. Dr. Leon, as Dean, do you have responsibility for the nurses' training as well?

Dr. LEON. Thank goodness, no.

Mr. MCEWEN. All right.

Dr. LEON. Dr. Coon does.

Mr. MCEWEN. Can you tell me whether or not the University of Pittsburgh has a training program with this facility here?

Dr. LEON. Our program in this facility is just beginning. We have just amalgamated the psychiatric services at University Drive and in this facility, and we are trying actively to steal faculty from the National Institute of Mental Health. We have been successful so far. We have recruited a couple of very distinguished people joining us.

We will open a residency here if the central office can fund it.

Mr. McEwen. If the central office can fund it. OK.

If we wanted to pursue that, do you have—are there any pitfalls that we should be aware of, or any reluctance on the part of the university to establish such a program?

Dr. Leon. No reluctance whatever. We are enthusiastic about it. We have been working on this for 5 years.

Mr. McEwen. Do you think that would be a solution to the nursing shortfall in this facility?

Dr. Leon. No, sir. It won't touch it. We are talking about training physicians not involved in the nursing relationship with this facility. The dean of the school of nursing is responsible for this phase of the program.

Mr. McEwen. Perhaps I didn't hear all of his words. That was my goal.

Dr. Leon. OK. I understand.

Mr. Edgar. I think he is talking about medical staff, and you are talking about——

Mr. McEwen. Nursing. My question was, Could we establish one, and would the university be willing to pursue discussions of that?

Dr. Leon. Probably so. We do have our own psychiatric hospital as a free-standing unit and—but yes, we would certainly entertain the opportunity.

Mr. McEwen. If we did pursue a nursing program at this facility, would that help solve the nursing shortfall?

Dr. Leon. No.

Mr. McEwen. Why is that?

Dr. Leon. Simply, it is an educational program. To solve the problem, the jobs must be attractive. That is the idea. I believe that the director is doing the best possible, considering the salary, the minor shortfall for first-entry staff nurses, the problem is in the fringe benefit package, particularly as pertains to education. It is really as simple as that.

The problem probably varies from community to community.

Mr. McEwen. Is there anything the university could do to assist us, since this area is so—has such a large number of educational facilities, and since a nurse working in an educational-associated-related hospital could thereby receive educational benefits her children, his or her children?

Is there any way that we can have an amalgamation of our efforts to assist the training of doctors or nurses through the VA, and also have certain employees of VA have concommitant educational benefits as a part of that package? Is that feasible?

Dr. Leon. I think absolutely. Speaking for the University of Pittsburgh, and I think I am privileged to speak for the entire university is some circumstances, the university has the capacity, and would welcome the opportunity to engage in that activity.

Mr. McEwen. Thank you.

Mr. Edgar. Thank you.

If there are no other questions, I would like to thank you for your testimony this morning. We will be back in touch if we have additional questions.

Mr. EDGAR. I would like to insert in the hearing record this morning a letter from Richard M. Scott, major general, the adjutant general of the State of Pennsylvania, who was unable to be here.

He points out in his letter three people who, I believe, are in the audience who I would just like to have stand and be recognized. Mr. John Balitis, who is director of the veterans' affairs; Albert J. Brown, deputy director of Veterans' Homes for Pennsylvania; and Stanley E. Snyder, commandant of the Soldiers' and Sailors' Home in Erie, Pa., where we will be visiting tomorrow.

Are they here in the audience? Please stand to be recognized.

[The letter follows:]

Dear Mr. Edgar: I am delighted to learn from your letter of 7 April 1983 that you and your Subcommittee will be visiting the Pennsylvania Soldiers' and Sailors Home, Erie, Pennsylvania, on 26 April 1983.

I sincerely regret that I will not be able to be with you on your Erie visits for the reason that the Adjutants General are holding their annual meeting on the same day and I am already committed to attend. However, I shall have present at this meeting, Mr. John Balitis, my Director of Veterans' Affairs; Mr. Albert J. Brown, Deputy Director, Veterans' Homes for Pennsylvania; and Mr. Stanley E. Snyder, Commandant of the Soldiers' and Sailors Home, Erie, Pennsylvania.

The Chairman of the Veterans' Homes Sub-Committee, Pennsylvania House of Representatives Military and Veterans' Affairs Committee, has requested information from my Department which he will share with you and your Committee at your Oversight Hearing in Pittsburgh. Should you desire additional information on our two state-operated veterans' homes, my Director, Bureau for Veterans' Affairs, Mr. John J. Balitis, and his Deputy for Veterans' Homes, Mr. Albert J. Brown, will also be present at the hearing.

One point I want to make is that there is one area of your interest and action that deserves continuous reiteration and support. Your sponsored Bill HB 1645, the derivative bill stemming from HB 103, it has the overwhelming support of the Commonwealth's veterans' community. A copy of the Veterans' Commission's letter supporting the concept of increased per diem is attached. We feel the bill is a step in the right direction and one that is needed to reaffirm the credibility of the Federal Government's stated policy of mutual sharing in the cost of care at our state operated Veterans' Homes. We do not believe that Senator Cranston's Bill S-629 suggesting only a 15 percent increase to the present per diem payments bites the bullet in the sense of meeting the Federal Government's fair share and/or mutual share of the cost of care provided at our homes. Our state legislators can easily become disillusioned with the concept of the state providing veterans' benefits, such as veterans' homes, when they observe the small Federal share provided for what the Federal Government contends is the most cost-effective long-term veterans' care available throughout the nation.

Thank you again for including the Soldiers' and Sailors' Home in your visit. We are very proud of the improvements that have been made at the facility over the past 4 years which covered major new expansions of nursing care, major rehabilitation of the old facility, greatly increased staffing and new administrative leadership. We think that we are on the right track, both at Erie and Hollidaysburg. Likewise, we are looking to the establishment of a third veterans' home in the eastern part of Pennsylvania, as recently proposed by Governor Thornburgh.

We appreciate your past and continued support in achieving our goals of expanded help for our veterans.

Sincerely, Richard M. Scott, Major General (PA) The Adjutant General.

Mr. EDGAR. Before we call on our next witness, who will be our State representative who has a great deal of concern about these issues, let me just describe for you something that is going to begin to happen up here on the stage, and I just want the audience to know what our plan is.

We are running a little bit behind in our schedule, and it was my intention to have as much opportunity for the members of this subcommittee to see and feel and touch the patient areas, talk to the patients, listen and hear some of their views and concerns.

I have asked that the hospital directors this afternoon divide up the groups into three, four, and five people, so that we don't overwhelm patients in the patient areas.

I am going to ask, after our next witness, that the members of the subcommittee peel off in groups of three and four and proceed to the area where we are having lunch, and then they will begin their tour of this facility, which will end somewhere in the neighborhood of 1:30, and then we will proceed to the second and third facilities, so this afternoon, we will keep on track.

So, as additional witnesses come to the table, they see some of us peeling off for lunch, you will recognize that they are not only peeling off to have lunch, but to move as quickly as possible on the tour, so that they can have a chance to meet and visit with the staff and the patients of this facility.

Also, they will have access to the total hearing record. All of your statements are before them, so that those of you who feel as though you are not being heard by all of these members, many of them have already read the good statements that you have put together.

Our next witness will be Hon. John F. Cordisco, chairman of the house military and veterans' affairs subcommittee of the house veterans' affairs committee for the State of Pennsylvania in Harrisburg. Would you please come to the witness table and bring your colleague.

John, we are real pleased to have you here today. We appreciate your ability to fly in and take that long ride from the airport and make it in time for your statement. We deliberately slowed up this morning—no, we didn't really—but we appreciate your coming, and taking the time. We know of your role in the State of Pennsylvania and its interest in providing adequate and quality care for veterans.

I would ask that you introduce your colleagues at the table, and proceed as you see fit.

STATEMENT OF HON. JOHN F. CORDISCO, CHAIRMAN, HOUSE MILITARY AND VETERANS AFFAIRS, SUBCOMMITTEE ON VETERANS HOMES, PENNSYLVANIA HOUSE OF REPRESENTATIVES, HARRISBURG, PA., ACCOMPANIED BY ROBERT HOLLIS, SENIOR RESEARCH ANALYST, PENNSYLVANIA HOUSE OF REPRESENTATIVES; AL BROWN; AND JOHN BALITIS

Mr. CORDISCO. Thank you, Mr. Chairman.

To my far left, we have Mr. Al Brown. To my immediate left, we have Robert Hollis, who is a senior analyst for the house of representatives; and of course, to my right, Mr. John Balitis, the two gentlemen to which you have introduced previously.

Mr. EDGAR. Before you begin your statement, I would like to say, Mr. Hollis, that we deeply appreciate your help in putting these hearings together today, and your assistance to my staff of the House Veterans' Affairs Committee. It has been a close working relationship, and you have been invaluable in the way in which you have provided that service.

Mr. HOLLIS. Thank you, Mr. Chairman.

Mr. EDGAR. John, you may proceed at this time.

Mr. CORDISCO. Thank you, Mr. Chairman.

Mr. Chairman, members of the Subcommittee on Hospitals and Health Care, Committee on Veterans' Affairs, and Members of the U.S. House of Representatives.

It is indeed an honor to appear before you today to present an overview on the operations of the veterans' homes within Pennsylvania as well as our future requirements and recommendations.

The Commonwealth of Pennsylvania provides its veterans the service of two veterans' homes. One is located in the beautiful rolling hills of Blair County in the environs of Altoona at Hollidaysburg, the county seat.

Our second home is located on the shore of Lake Erie in the northwestern portion of the city of Erie.

Both homes have ongoing construction programs to improve or increase the physical plants. Hollidaysburg Veterans Home has 202 nursing care beds and 179 domiciliary beds.

However, it has a program goal to reach a total of 600 beds by 1986, 425 of the beds will be for nursing care and 175 for domiciliary care.

The Pennsylvania Soldiers' and Sailors' Home, located in Erie, presently has a new 75-bed nursing care unit, and a 100-bed domiciliary unit which has been modernized to meet all of the most recent advancements in home-style living accommodations for its residents.

The home provides not only domiciliary care, but has a limited number of more intensive personal care beds for those veterans requiring care below the level of nursing care.

The primary objective of the veterans' homes programs it to provide a home-like environment that allows the highest level of resident care available. Accordingly, a full range of services, including full-time resident physician, nursing care, social services, physical therapy, and therapeutic recreation activities is available to help each resident reach the fullest use of his mental, physical, and social capacities.

Our homes are inspected by the Veterans' Administration and surveyed by the Commonwealth's Department of Health annually to insure that we meet both Commonwealth and Veterans' Administration health care standards and staffing patterns.

Veterans are admitted by applications procured from the local county directors of veterans' affairs or service officers of national veterans' organizations.

Since both homes are normally fully occupied, a waiting list for each type of care is maintained based upon the date the application is received by the Department of Military Affairs.

Both homes provide skilled and intermediate nursing care as well as domiciliary or personal care. The domiciliary waiting list moves reasonably fast. Unfortunately, the nursing care beds may require a year or more waiting time, which is comparable to the Veterans' Administration nursing care facility waiting lists.

The operating costs of our two homes this fiscal year are estimated at $11.8 million with funding sources as follows:

State funds, $8.3 million; Federal funds, $1.15 million; resident fees, $1.8 million; and aid and attendance payments for nursing care patients estimated to be $437,000.

The proposed budget for the 1983–84 fiscal year is $14 million, with the State share being $9.6 million; Federal, $1.7; and residents' fees, $2.1 million.

In 1977, in response to the recommendations by the House Military and Veterans' Affairs Committee, the department of military affairs implemented a maintenance fee program requiring the residents of our State veterans' homes to contribute toward the costs of their care based on their ability to pay.

This fee permits residents to retain a minimum of $100 per month, plus 20 percent of all remaining income from all sources.

I might add that in the event House Resolution 1645, sponsored by you, Mr. Chairman, is enacted into law, and based upon our current resident population, Pennsylvania would be eligible to receive approximately $457,000 more in Federal funds, thus enabling us to reduce our State share by an equal amount.

I would now like to discuss the VA/State construction program.

Since 1974, $5.4 million has been spent on improving the Erie Soldiers' and Sailors' Home with the Commonwealth financing 57 percent of these improvements.

Further, $6.9 million has been expended converting the Hollidaysburg State Hospital to a veterans' home, with the State funding 46 percent of the conversion costs.

We have requested an additional $5 million in Federal funds to complete the Hollidaysburg project. However, with the current $60 million backlog in VA construction grants, it means it will be 4 to 6 years before we can expect these funds, even though we have $2 million in State construction funds available.

There is much criticism by private nursing home administrators of VA and States building nursing home facilities; they allege they can build them cheaper. The problem is in standards.

In Pennsylvania, private for-profit nursing home construction ranges from a low of $22,000 to a high of $36,000 per bed with the mean at a range of $24,500 to $27,000 per bed.

The VA construction costs range from a low of $76,000 to a high of $150,000 per bed. State construction ranges from $30,000 to $50,000 per bed.

In Pennsylvania, our construction costs for the 75-bed nursing care unit in Erie was $30,872 per bed—no kitchen included and administrative space included. This was a new building, semidetached from the administrative and dietary building.

At Hollidaysburg, utilizing the concept of converting an existing facility, our costs were: Rush Hall, a 202-bed nursing care unit, $19,780 per bed; Neal Heal, 179-bed domiciliary unit, $16,409 per bed; and programed Sommer Hall, 225-bed nursing care unit, $19,041 per bed.

These units do not include a dietary unit. The renovations of the dietary unit are programed at $1.1 million and the boiler plant improvements at $279,000.

If we prorate these costs to each bed, it would increase the per-bed costs by $2,290. The average nursing care bed construction costs would then be $21,000 and the domiciliary, $18,000.

Current planning for a third home in eastern Pennsylvania is to construct a home with 200 to 350 nursing care beds and 75 to 150 domiciliary beds. Basing the cost on our experiences at Hollidaysburg, and considering eastern Pennsylvania as a high-cost construction area, the cost for a 275- to 500-bed facility would range from $23,000 to $30,000 per bed if an existing facility were used. The State cost, at 35 percent, would range from $2.2 million to $4 million.

However, under current VA funding limits, Pennsylvania cannot expect to receive support to construct this vitally needed home for at least 7 years, a home that would support the needs of our veterans in the most populous area of the Commonwealth.

Action must be taken to increase this funding level if the various States are to continue providing care for our aging veterans, care that is rightfully the duty of the Federal Government to provide, but one that the States are ready and willing to assist if the proper support was forthcoming.

This, Mr. Chairman, completes my statement. I will attempt to respond to any questions you might have.

[The statement of Mr. Cordisco appears on p. 99.]

Mr. **Edgar**. Thank you very much for your comprehensive statement.

On page 3 of your statement, you talk about the cost of building State nursing care facilities as compared to that in the private sector and in the Veterans' Administration.

I would like to state for the record that I don't believe you need to apologize to anyone regarding the State's cost.

The staff of the Veterans' Affairs Committee has visited several nursing care units constructed in similar State home facilities, and has found both the quality and the quantity of construction and the care superb in these facilities.

The care provided for veterans in these facilities is generally more complex and requires more intensive nursing care than usually found in community facilities and is the most economical and cost-effective program for the care of veterans in which the U.S. Government participates.

The chairman of the full House Veterans' Affairs Committee has corresponded with the Director of the Office of Management and Budget and the Administrator of the Veterans' Affairs area, concerning the $60 million backlog currently that currently exists for State veterans' extended care facilities throughout the country.

Mr. David Stockman has responded that in fiscal 1985 and beyond, efforts will be made to begin substantially to reduce that backlog. Unless we can do this, I don't believe that the State will continue to be encouraged to continue in such a program. Should this occur, it would be, in my opinion, very tragic.

I would want to point out one concern I have about your statement, and it is still a mild concern, but it is still a concern. I am the author of the bill cosponsored by many members here to increase the per diem rates in the State homes.

I noted on page 3 of your testimony that you mention the per diem increase will enable us to reduce the State share by an equal amount. It was our hope that some of that might be true, but that in fact, the State might keep its commitment pretty much where it is, and we would give additional help and additional ability to use the limited resources of the State more wisely for other veterans and other needs.

The bill which I have introduced provides the first increase in 3 years in per diem rates. It puts the Federal funding level at about 30 percent, which was the traditional amount of Federal commitment to the State homes. It had been allowed to slip way down to about 20 percent over the last few years.

So, there will be additional funds. We do encourage those funds to be made available. We have had to fight tooth and nail with the administration to agree to an increase in the funds, and I believe that it is on track to see it passed and become law.

I just urge you to take a look to see that the increase is not a way for the State to reduce its commitment, but to see it as a way to provide help for other State facilities.

Also, on page 3 of your statement, you indicate that the Commonwealth of Pennsylvania has financed improvements of the two State veterans' extended care facilities, greater than would be expected. The grant program authorized by the Veterans' Administration can provide up to 65 percent of the cost.

Is there a reason why the Commonwealth of Pennsylvania had to pay 57 and 46 percent, respectively, in the improvements and conversions of these two State facilities?

Mr. **Cordisco**. Mr. Chairman, I will refer that question to Mr. Brown.

Mr. **Brown**. Mr. Chairman, there [illegible] is. For example, the home you are going to visit tomorrow, [illegible] Pennsylvania Soldiers' and Sailors' Home, we have a here [illegible] situation, and we could not wait for the 65-percent allocation [illegible] VA.

The Governor, who is very compassionate to the needs of the veteran, appropriated $1,400,000 for immediate renovation of that home. That was one of the biggest examples of here-and-now type of funding for the needs of the veterans at this present time to make our home the home that it is, but you will see tomorrow, and I am sure surprised, that this facility is one of the finest veterans' homes in the Nation.

Another area is, that as we go on in construction, and we are building, we find many times we have to make improvements over the present allocation that we were authorized, and here again, it is a here-and-now situation. In order to continue on the construction and get it done, there is a limit as to how much the VA will support on change orders.

The Commonwealth will not wait for this change. They move right ahead to get the homes accomplished so that we can fill those needed beds.

Mr. **Edgar**. Thank you very much.

And I would point out, on the last page of your statement, the establishment of a State home in the eastern part of the State; I come from beautiful downtown Delaware County, which is in the eastern part of the State. I would support you in terms of the establishment of that facility.

I think some of the work we now can do with my active involvement as chairman of this subcommittee. I think we can work very closely together on the establishment of those facilities.

We really look forward to our visit tomorrow in Erie, and hope that that is an example of our strong commitment to the increase in per diem, and to the value of those State homes.

You mentioned the Governor's role in this. I think the State legislature has also played an important role. And like our Washington committee, I know that there is very little partisanship in the veterans within the State capitol. I am pleased that both Democrats and Republicans have worked very closely together in establishment of a commitment on the part of the State to the veterans' needs.

Other additional questions?

My colleague, Doug Walgren.

Mr. **Walgren**. Mr. Chairman, thank you.

I would just like to underscore the witnesses' testimony, because I think it is very significant. It is clear that a Federal-State sharing program can conduct these efforts most cost effectively, when you compare the dollar costs of these beds, something appears to be going wrong on the Federal level.

And I think we ought to do everything we can to encourage States to join in this. And it comes as somewhat of a surprise to me, and perhaps to some other Members of Congress, that the States are out ahead of us on this.

When we look at the amounts that they are contributing, the Federal Government is contributing literally one-tenth of what the States are to this program, so I think that that should be really a warning flag to us on the Federal level that we may not be supporting our end of that effort.

And I do want to certainly commend what is being done in the State of Pennsylvania and hope other States will follow in that way. But it should be a fair warning to us on the Federal level that if we are to get them to do that, we have to carry our share of the burden, also.

Thank you, Mr. Chairman.

Mr. **Edgar**. Thank you for your statement.

I yield to my colleague from Florida.

Mr. **Bilirakis**. Well, gentlemen, I don't know that I would expect an answer from you on this, although God knows we ought to get an answer from somebody at sometime or another.

But we had testimony previously in the hearing called by the chairman regarding this subject, in Washington. And it seemed that the per diem costs in the State-supported homes were considerably less than the per diem costs in the veterans' homes, veteran medical centers.

I also see here that apparently the construction costs are fantastically different. We aren't doing our jobs if we don't find out the answers to these questions, and I am not sure that I am directing these questions to you. If you have any comments, please forward them, but it is something that amazes me.

Mr. CORDISCO. Mr. Chairman, Mr. Balitis would like to respond to that.

Mr. BALITIS. There is a drastic difference in what the Federal Government pays for construction and the State does. The reasoning is that most of the VA facilities are attached to a real medical facility.

In the State, we get ground donated, as an example. We convert facilities. This affects the cost of doing it, and I can say, from the experience in Pennsylvania, that we have had in our two homes, which are both on a major construction program, our costs, we have helped maintain them and keep them down for the simple reason, it is a home project. It is right here in this State.

The funds to do the job are somewhat limited, based on what we get from the Federal Government, certainly subsidize it. But we have a very stringent control on our construction and the direction we are going. We go with the idea of what we can afford, in a lot of cases.

In the per diem rate, you are right. We in the homes in the State of Pennsylvania—again, that is where I have to limit my discussion—are aware and very sensitive to costs. We are continually required to justify every dollar we spend.

I am not saying that the VA is frivolous in their spending, but I am saying it is just like if you are running your own project at home, the dollars and cents are a major factor. In going along with what the chairman said, that with the increase in per diem, I am sure it won't lower completely what the State is putting in, but it certainly will give us some additional services that we can't provide now, and it certainly will help the State justify its expenditures.

But it boils back to a local item, responsibility of the State to monitor what is going on, to keep costs as low as they possibly can.

Mr. BILIRAKIS. Better efficiency, more efficiency, that is really what it is, isn't it?

Mr. BALITIS. Yes, sir.

Mr. HOLLINS. Sir, if I may just interject one statement. We have, in Pennsylvania, and I say Mr. Brown and his people who operate the veterans' home, have established the third level of care called intensive personal care, which is between the domiciliary and the nursing care.

We do not get subsidized for this, other than at the domiciliary rate, but these are dealing with people who require maintenance, extensive maintenance to keep them going, provide them medication. It frees up some nursing beds. They would not be able to be in a domiciliary unit. They would be required to be in a nursing bed.

But by having this third level of care in between, we maintain them in a dom unit with some more staff within that unit, rather than tying up a nursing bed, which may be needed for someone else.

We think that there should be some consideration for establishing, maybe, a third per diem level in between the domiciliary one proposed by the chairman, of the $9.50 and the $16 for nursing, somewhere in the neighborhood of $12.

You may free up some of this nursing money if you could set up this type of a program. Just a suggestion.

Mr. **Edgar**. One of the things we want to do, in light of Mr. Bilirakis' question, which is a really important one, is to do an intense, focused study on the question of delivery of care and cost of construction of these type facilities, to figure out why it costs the Federal Government so much money.

We have seen some outrageous numbers of the costs per bed for a Federal facility, and it doesn't all relate to the Davis-Bacon Act, it doesn't all relate to labor rates, it doesn't all relate to the Federal Government getting ripped off, but it does relate to some structural problems that we have in the development and construction of these facilities, and we really appreciate your leadership.

Other additional questions anyone has?

Do you have an additional comment? I see you jotting some notes there.

Mr. **Cordisco**. Yes; I just have one further comment to make, Mr. Chairman.

I believe if we were to increase the funding from $15 million in construction to at least $30 million yearly, we can cut that 7-year projection to possibly 3 years.

If not, at the rate we are going at the present time, we can look toward 3 years additionally with construction, so that we might not see that third home for at least 10 years.

I believe that there is a need, of course, both of us coming from basically the same section of the State, that being the eastern, southeastern section, and we are both aware how many veterans we do serve, and I think it is important for them to at least to know that we are making every attempt to help them in this particular project.

Mr. **Edgar**. In conjunction with that, the Philadelphia Veterans' Hospital is in line for about $184 million commitment to renovate the acute care facilities and to establish across the street a 120-bed nursing home facility, and to build a new ambulatory care clinic on the old Philadelphia General Hospital site.

We are hoping that that will also stay on track, to provide additional help in eastern Pennsylvania. The Philadelphia Veterans' Hospital is the only major hospital in the State that doesn't have associated with it some type of nursing home facility.

In light of the fact that the Camden, N.J., hospital was deleted from construction and funding, we think that the acute care facility in Philadelphia ought to be upgraded in terms of quality of care and that nursing home facilities ought to be provided in the eastern part of the State.

I really look forward to working with you over the next several years to try to provide adequate care. I think we can get passed the per diem increases, and I think we can provide some pressure on the Office of Management and Budget to free up the funds for the construction phase and program through the States, because of the economical nature of your program.

Thank you very much for your—gentlemen, very briefly if you could.

Mr. **Brown**. Mr. Chairman, I would like to acknowledge a man standing behind you, Mr. Ralph Casteel. In my work with your commission, we found that he is a very responsive individual, ready and available to give us help, to our Pennsylvania veterans any time we have it.

Also, to make one more announcement, to Florida, who is coming on line, following Maine and Maryland, in the preparing to come out with a State-operated veterans' home.

Mr. **Edgar**. Thank you, Mr. Brown.

Mr. **Cordisco**. Mr. Chairman, I commend you for your efforts with your committee today. Thank you.

Mr. **Edgar**. Thank you very much. I appreciate your coming.

Our next witness will be Dr. John B. Coates, Jr., brigadier general, U.S. Army, Retired, Pennsylvania Department Surgeon, Veterans of Foreign Wars.

Dr. Coates, we appreciate your coming today, and in lieu of the time and time pressures that we have, I hope that you might be able to summarize your statement. Please introduce the gentleman who is with you today.

STATEMENT OF DR. JOHN B. COATES, JR., BRIGADIER GENERAL, U.S. ARMY (RETIRED), PENNSYLVANIA DEPARTMENT SURGEON, VETERANS OF FOREIGN WARS, ACCOMPANIED BY BOB SMITH, STATE VFW SERVICE OFFICER, PITTSBURGH, PA.

Dr. **Coates**. Yes, sir, Mr. Chairman, I have with me today Mr. Bob Smith, State VFW service officer, stationed and located here in Pittsburgh.

Mr. **Edgar**. Very good. Welcome to our committee hearing this morning.

Dr. **Coates**. Mr. Chairman, members of this subcommittee, I am Dr. Coates, as has been announced, and I represent today the Veterans of Foreign Wars of the United States of America, Department of Pennsylvania.

State Commander Thomas J. Dougherty, whom the chairman has met, discussed, and corresponded with, asked me to appear before your important committee. I am very happy to do so.

I am a retired brigadier general of the U.S. Army Medical Corps. It has been my honor for the past 7 or 8 years to serve as the department surgeon of Pennsylvania VFW.

I have made it a very high priority to be as well-informed as possible as to the medical care afforded veterans of the United States here in Pennsylvania by the VA.

I might add, too, that I consider it a high privilege to have been elected as the national surgeon general of the VFW in 1979-80, and to have served in that capacity.

Since 1975, on a yearly basis or more often at times, I have had the opportunity to visit all 10 of the various medical centers operated by the Veterans' Administration in the great Commonwealth of Pennsylvania, spread across our land, as they are, from Pittsburgh to Wilkes-Barre and from Erie to Philadelphia.

I have utilized these many opportunities thus afforded to discuss the medical care rendered to our veterans with the doctors, nurses, administrators, and many other dedicated personnel who are associated with these medical centers.

And, with much more than casual interest, I have seen at first hand, during these 9 years, the actual services rendered to these veterans.

Furthermore, the more than 200,000 members of our State VFW and its auxiliary have given me valuable input and helpful information regarding matter coming to their attention, in addition to their personal observations.

Further, it has been my privilege, since 1975, to be a member of the dean's committee of the Coatesville VA Medical Center, Jefferson Medical College of Philadelphia, which committee is chaired by Paul Fink, M.D., the distinguished professor and chairman of the department of psychiatry and human behavior at Jefferson.

The function of this committee, serving as it does, and meeting monthly, to advise, assist, and monitor the clinical care of patients, and the program of research and education at the Coatesville Medical Center, has sharpened my conviction of the worthwhileness of close affiliation between the VA medical facilities and the medical colleges and universities nearby.

It is good for both. And it strengthens the capabilities of both the VA medical center and the university for the betterment of the patient.

So much for background information.

The State of Pennsylvania Veterans of Foreign Wars believes in and firmly supports the medical activities of the Veterans' Administration. We would fight to the last man to retain the Veterans' Administration.

On the whole, we believe that the VA is providing medical care to veterans which is equal to and perhaps better than would be provided in the local civilian community. This varies, of course, with localities.

Those VA facilities which are affiliated with large universities and medical schools are staffed largely by the university personnel. The capability for and the caliber of medical service in those hospitals is unexcelled anywhere.

In addition, it should be pointed out, the availability and use of consultants in the various specialties at other VA medical facilities is helpful in maintaining a very high level of medical/surgical care in the staffing of other VA hospitals.

I would like to say a few words about personnel staffing of the VA medical centers located in Pennsylvania. Generally speaking, it is my professional impression that the number of doctors assigned are generally adequate in numbers and professional competence.

This is not to say that there is any surplus. There is not. And, in some hospitals, on certain services, additional physicians could be gainfully utilized.

The Old Leech Farms Hospital, on the grounds of which this meeting is being conducted, and the Lebanon VA Medical Center come to my mind as possible recipients of additional psychiatrists to assist with the workload and the rehabilitation process.

From my observations, likewise, it is my opinion that VA medical centers could utilize additional nursing personnel. Their numbers are what I consider borderline, and this applies to all within my cognizance. I would like to see them increased. In so doing, the staffing would be more compatible with that found in the better community or university hospitals of our land.

Now, the management of VA medical facilities is, on the whole, to be commended, in my opinion. These are, on the whole, dedicated, hard-working, intelligent, and skilled individuals.

They are understanding of the many complex problems dealing with medical care in the broad sense. They are understanding of the problems of veterans and the problems with which veterans must contend.

They are cooperative with veterans' organizations, and they appreciate the assistance which the latter offer. And they must and do contend with many outside intrusions into their domain of responsibilities.

They are cost conscious, but they wish their patients to have that which is required for the best possible care. They do their best to maintain as modern and safe and clean an installation as possible.

They are generally cooperative and understanding of the needs of their professional staffs. The presence of modern equipment in VA hospitals attests to their concern in that area.

In recent years, gentlemen, there has been a trend in VA medical facilities to treat patients on an outpatient basis whenever possible. Civilian physicians and civilian community hospitals are doing likewise. It makes sense. It is much less expensive.

The VA has had to adjust accordingly. And this has required alternations within the hospitals, both in structure, professional staffing, and in other ways.

This is a good trend. I have yet to find an inpatient who would not rather be at home with his loved ones than in the hospital away from his family.

Where indicated and possible, outpatient care for veterans should be encouraged, bearing in mind, however, that each case must be based on its own professional requirement.

In closing, I would like to offer a few comments regarding nursing homes as well as domiciliary facilities, as I see them.

Mr. EDGAR. Dr. Coates, if I could interrupt you at this point, I have read the three or four additional paragraphs of your statement dealing with nursing homes, and we have, in fact, heard from other witnesses on that issue.

I wonder if you might summarize, in your own words, your concern and commitment to the State homes. The full text of your statement will be made a part of the record. Then we could move to questions and hear from some of our other witnesses, and give us an opportunity to see this great facility.

Dr. COATES. Yes, sir, thank you, Mr. Chairman.

I would like to substantiate those remarks that have been made ahead of me, as far as the need and utilization of the State homes. I think they are needed, and I think Pennsylvania is to be commended for having two of them in operation at the present time.

I would urge your cooperation, because I know that you and your committee, Mr. Chairman, can do a great deal to further the use of these homes in this State, and to help them financially, as well as in all States who are really financially pressed.

[The statement of Dr. Coates appears on p. 104.]

Mr. **Edgar**. Thank you very much for your statement. It was, in fact, comprehensive, and your experience has been very thorough here in the State of Pennsylvania, and understanding the need for veterans' health care facilities.

Do either of my colleagues have question at this point?

Mr. **Bilirakis**. I have no questions, sir. I always have, of course, the one underlying question which was raised by the dean, and which was not answered, I think. And that is how do we prepare for these astronomical costs which we are looking ahead to for the next decade or so, and I certainly don't expect a comprehensive answer from General Coates.

But it is something that we would like to hear about to help us do our job better.

Dr. **Coates**. Thank you, sir.

As a physician, recently retired from active practice, I can tell you that I am very much concerned about the rising prices of medical care. I don't know a single doctor of my acquaintance who isn't similarly concerned.

I happen to be on the cost-control committee of Paoli Memorial Hospital, as an emeritus member of their staff, and we are concerned, and we don't seem to be able to do a lot about it.

From the standpoint—there are two raises—there are the doctors and their hospitals. And I think it has been shown that the hospitals take a fair share in the yearly raise in costs.

Doctors are also not inblamable.

I wish I could tell you, but I think you have to figure out what is the cost of inflation annually, and go on that general basis.

Mr. **Bilirakis**. Thank you, General.

Mr. **Edgar**. Dr. Coates, do you know of the issue of developing a 120-bed nursing home facility in the Philadelphia area? I just wonder if, from your experience with the Veterans of Foreign Wars, whether that is a needed facility?

Dr. **Coates**. Thank you, Mr. Chairman. I have tried to support that long before the VA hospital was able to gather the old property of the Philadelphia General Hospital, which you have alluded to and mentioned, and which I am very happy to see.

That Philadelphia VA Hospital, as you know, is very much jammed into a very small building and to a small area. That should help some.

However, I believe that the number of veterans in the southeastern portion of our State certainly warrants more than 120 beds for nursing-care purposes in addition to domiciliary beds, if you will add them in, too. I support it very much.

Mr. **Edgar**. Thank you very much for your strong support and strong statement, and we appreciate your taking the time to appear before this committee at this time.

Dr. **Coates**. Thank you very much, Mr. Chairman, and the committee, for the opportunity to present these comments.

Mr. **Edgar**. Our next witness is Mr. Ed Hoak, adjutant, Department of Pennsylvania, American Legion. I think there may be some colleagues coming with you, Ed, and I appreciate your patience today in listening to the statements that were made.

STATEMENT OF EDWARD T. HOAK, ADJUTANT, DEPARTMENT OF PENNSYLVANIA, THE AMERICAN LEGION, ACCOMPANIED BY CHARLES McGUIRE, ASSISTANT DEPARTMENT SERVICE OFFICE, THE AMERICAN LEGION; AND ROBERT BISHOP, DIRECTOR, GOVERNOR'S VETERANS' OUTREACH CENTER, NORTH HUNTINGTON, PA.

Mr. HOAK. First of all, I would like to introduce the two people with me. To my left is Charles McGuire, one of our American Legion assistant service officers stationed in the Federal Building in Pittsburgh.

To my right is Robert Bishop, who is the director of our Governor's Outreach Veterans' Assistance Center in North Huntington, Pa., which is funded through the Governor's office, but which is supervised and sponsored by the Department of Pennsylvania American Legion.

Mr. Chairman, Mr. Edgar and members of the Subcommittee on Hospitals and Health Care, I wish to thank you in behalf of the 250,000 American Legionnaires of Pennsylvania for giving me this opportunity to express the views of our veterans concerning the quality and the quantity of health care being provided to eligible veterans in western Pennsylvania.

I would like to first say that we, as Legionnaires and as veterans, greatly appreciate the excellent medical services that are rendered by the VA medical centers in the State of Pennsylvania and especially in western Pennsylvania.

These medical centers of the State enjoy an excellent reputation among the veteran population of the State. It is great that our Federal Government gives such excellent medical service to our people.

Since the VA has 10 medical centers in Pennsylvania, we are very much aware of their activities, the good things that are said and the complaints.

In regard to current VA hospital care in the area, for the past years we have received many complaints from the veterans who have been compelled to be hospitalized that there is a shortage of nurses, both at the Aspinwall and the Oakland Medical Centers, which many times actually results in poor patient care.

These complaints have been presented to the director on several occasions. We have been informed that it is most difficult for the VA medical centers to be competitive when recruiting nurses and keeping them on the payroll because of the other hospitals in the area that offer more fringe benefits.

If the VA medical centers are to continue the good name of excellent medical care, then much attention must be directed to the recruitment of nurses and maintaining them on the staff. This would mean budget increases in nursing.

Funding must always be increased for salary adjustments for certain technical positions. Laboratory technicians are especially difficult to recruit with the present salary disparity in excess of $4,000 a year in many of the positions.

Probably one of the greatest criticisms of the Oakland VA Medical Center, and one which has actually nothing to do with medical care itself, but that is the horrendous parking problem at the hospital, and if this meeting would have been held where it was originally scheduled, I am sure that I wouldn't even have to discuss this problem, because you yourself would be acquainted with it.

It is nothing to sit in your automobile for 2 hours waiting for a parking place for patients, volunteers, and visitors.

Can you imagine the stress and the frustration that this would cause a veteran seeking outpatient service? Directly, it might not have anything to do with medical care, but it sure has something to do with frustration.

Every effort should be made to speed the construction of the ambulatory care wing, which will expand that care area, the pharmacy, the laboratory and various other departments. This expansion is very important to the growing number of veterans who will be seeking medical services from the VA medical center.

A year ago, I had the occasion of taking a veteran to the VA medical center for outpatient treatment. Upon arrival, he was given the number 92. This meant he would be waiting until the clinic closed, he would be housed overnight, and then receive treatment the following day, and he then had to seek public transportation to his home 40 miles away.

Any concern for medical care for the veteran is the shortage of nursing care beds for our aging veterans who are suffering from many chronic conditions. It is my understanding that in the VA medical district No. 5, there are 405 nursing care beds, and that they are filled to 99.5 percent capacity with a waiting list at each VA facility.

Pennsylvania has two State veteran homes, one in Erie and the other in Hollidaysburg, where there are an additional 182 beds.

This is probably the time that I should mention the American Legion's support of legislation for increasing the per diem rates paid by the VA to the State-owned and -operated veterans' homes.

H.R. 1645 is very important to the future of State veterans' homes, and Pennsylvania has two fine homes that became a reality through the great efforts of our Gov. Richard Thornburgh, who has shown much compassion and interest for the veterans of the Commonwealth.

It is very apparent with the World War I veteran now at the average age of 86; the World War II veteran at 61; the Korean veteran at 52; the Vietnam veteran at 35; that we will be soon moving into those critical years when more nursing care and domiciliary beds will be needed to take care of our aging veterans.

Let me say this: Many veterans have never received any service-connected compensation or hospital care. But yet they fought the battles of this country, and with God's blessing never once required hospital care or anything from their Government.

But now, and very soon, they will be in need of such care and a grateful Nation cannot ignore their pleas for care and attention.

Let us never forget these veterans gave so much but never cried for help until now in later years, requires medical attention in dignity. The term non-service-connected is not fair to those veterans who fought our battles.

I am sure that I need not remind the members of this committee of the financial distress of our unemployed veterans here in western Pennsylvania. Just recently, the Pennsylvania American Legion held a job clinic in Charleroi, Pa., where 200 unemployed veterans were informed of their rights and benefits in regard to the employment service, VA regulations, education benefits, public assistance, and bank foreclosures.

And from these clinics, it was stated many times by the unemployed veteran that their greatest concern was health insurance for themselves and their families. If such unemployment is to be continued in this country, then it can be expected that many veterans will be turning to the VA medical centers for health care for themselves, since they will no longer be able to afford health care insurance.

The VA health care system must give greater consideration to the veterans who were victims of agent orange and other herbicides in Vietnam. Outpatient service and hospitalization must have a high priority in caring for our younger veterans and helping them with their herbicide and stress problems.

VA outpatient clinics are very important to the veteran, especially the procedures and the means that the services are delivered to the veteran. Delays, lack of feeling, crowding, and indifference do nothing but create even more problems.

Therefore, it is important that the outpatient clinics are large enough in size to handle the patient load and are conveniently located near the veteran and properly staffed with a qualified staff.

Any new procedures that would restrict the number of visits that a veteran could make to an outpatient clinic would be a great injustice since this is often the most effective, efficient method of giving medical care to the veteran.

In closing, I again wish to thank you for the opportunity to express some of the views of the Pennsylvania American Legion regarding the health care of our veterans in western Pennsylvania. The VA system is great. I am sure that the House Veterans' Affairs Committee works with constant problems of improving the medical care with the funds that are available, and this is truly appreciated.

We have great praise for Mr. Gigliotti and the staff that renders this excellent medical care to our veterans.

Thank you very much.

Mr. EDGAR. Thank you very much for your comprehensive statement. The points that you make are well taken. The American Legion has been a leader in reviewing hospitals and going out and making hospital visits and we commend you for that.

I would like to yield at this time to my colleague from West Virginia, who has an important statement to make.

Mr. MOLLOHAN. Mr. Chairman, thank you very much. I appreciate the testimony here today, and as the chairman has mentioned, the American Legion has been a leader in hospital visitations and preparing reports on hospitals that it does visit, and to me, it has been particularly helpful with regard to the Clarksburg VA Medical Center in Clarksburg, W. Va.

Mr. Chairman, there is a crying need for an expansion of that hospital, and that need was referenced and supported in the American Legion report dated July 23, 1982, which was prepared subsequent to the VA inspection of that hospital.

And I would like to make a part of the record that report, Mr. Chairman, to verify the crying need for an expansion and renovation of that hospital which was originally constructed in 1951. I would like to submit the whole report, but I would just like to read these two sentences into the record, and I quote from page 3: the "medical center was described as bulging at the seams, the planned clinical addition will take care of space needs, and it was deemed a must to provide treatment as it should be given."

Mr. Chairman, I would like to submit this report in the record at this time.

Mr. **Edgar**. Without objection, this American Legion report will be made a part of the record at this point.

[The information appears on p. 118.]

Mr. **Edgar**. Are there additional questions from my colleagues? Let me just ask you one or two questions.

There are various proposals being discussed in Washington at the present time for expanding health benefits for unemployed workers.

As we have heard earlier, catastrophic unemployment rates in this region are forcing more and more veterans to turn to the VA for health care.

Our first priority is to put these veterans back to work. But, in the meantime, what do you suggest as the best solution for providing health care for these individuals who find themselves unemployed?

Mr. **Hoak**. As one unemployed veteran steelworker said to me at the job clinic, "Mr. Hoak, if there is anything that you want to do for the unemployed veteran, please give us the opportunity to at least have group insurance."

They said, "It is one thing to get unemployed, but then to go out on to the market and buy a single policy, we just can't afford it."

He said, "If you could try to group the unemployed steelworker veterans, or anybody, it would be a great help."

And since that clinic, I have been trying to do everything I can, through the insurance commissioner's office, everywhere, to try and get them into a group where they can get that reduced rate.

He said, "We don't want charity. We want to pay for it, but we want to have it available. We can go to the hospital clinics and things like that."

But he said, "What if some major disease hit us?"

And that is what they are after. They would like to be given the right to be a part of a group.

Mr. **Edgar**. There are a number of proposals in Washington, including one introduced by our colleague, Joe McDade, and cosponsored by a number of people, to look at ways to provide health care for the unemployed. It is an area that many of us are interested in, and we hope that the American Legion, not just for the veteran, but for all those who find themselves unemployed, will assist us in finding the most equitable way of providing that health care.

Mr. **Hoak**. It might help if the committee would let the veterans know that they could go. Some of them don't know. It is a matter of lack of information. If they could go to the VA medical center and pick up some of this health care. It doesn't help their family, but it helps them.

Mr. Edgar. Our visit here has caught the attention of some of the newspapers and a couple of the television cameras. I am sure that that will be at least raised in the consciousness of many.

The Pennsylvania American Legion is to be highly commended for taking the lead in providing employment outreach, training and placement services for veterans here in Pennsylvania.

I offered an amendment to the Job Training Partnership Act last year, which provided up to $13 million in grants to employment outreach centers such as the Governor's Veterans' Outreach Center here in Pennsylvania. Perhaps Mr. Bishop would care to comment on the status of that program?

Mr. Bishop. Thank you, Mr. Edgar.

I think that we are doing real fine. We appreciate your support, and we have currently the support of all the major traditional organizations in the Commonwealth, as well as the support of some new or younger veterans' groups.

An issue that we see today that is not a significant problem in terms of numbers, yet, but I think it will require your attention in the planning stages in years to come, and that is transportation to VA medical centers for indigent and elderly non-service-connected patients.

Thank you.

Mr. Edgar. I appreciate your adding that for the record, and I also want to underscore your support of H.R. 1645, and your commitment to increasing the per diem rates for State-operated veterans' homes. That is very helpful at this point.

One other thing, I meant to ask this of the VFW earlier, I have introduced legislation in Washington to rename the Altoona Hospital after Jimmy Van Zandt. And we need, in order to have that accomplished, the total support of 23 House Members from Pennsylvania, the two Senators, and each of the established veterans' organizations here in the State of Pennsylvania.

I wonder if the American Legion of the State of Pennsylvania has any opinion as to whether or not the Altoona Hospital should be named in honor of former Congressman Jimmy Van Zandt?

Mr. Hoak. The American Legion hasn't taken a position on that yet. We have had several recommendations on other people, and because we get involved in a popularity contest, we just haven't done it yet. We have not taken a stand on that yet.

Mr. Edgar. OK. I would hope that you would take a look at that issue. Jimmy has provided a great deal of service to the delegation in Washington and was active in the veterans' community, and has taken strong leadership. Until we get a letter of support from each of the State veterans' organizations, we will not be able to move that legislation forward.

And while Jimmy is still alive, it seems to me appropriate, given his age, I believe he is 84, he is probably 110, but he claims to be 84, and the pressure that he has been under medically recently causes us to be concerned and want to honor him in a significant way.

For those who don't know Jimmy Van Zandt, he is former Member of Congress on the Republican side in the State of Pennsylvania who was very active during World War I, World War II, and Korea as an institution in Washington, and serves as the secretary of the Pennsylvania delegation. He is a former national commander of the VFW, and a very active person within the veterans' community.

Mr. **Hoak**. All I could say is that Jimmy Van Zandt has been exceptionally good to the American Legion, worked very closely with him on many projects, and certainly your suggestion will be given consideration.

Mr. **Edgar**. Thank you very much for your testimony.

Mr. **Hoak**. Thank you.

Mr. **Edgar**. Our next witness will be Mr. Donald Graffius, State judge advocate, Disabled American Veterans, Department of Pennsylvania, and his colleagues.

Donald, I mispronounced your name as effectively as I could, and it would be helpful if you would pronounce your name for the record, and introduce those who are with you.

STATEMENT OF DONALD GRAFFIUS, STATE JUDGE ADVOCATE, DISABLED AMERICAN VETERANS, DEPARTMENT OF PENNSYLVANIA, ACCOMPANIED BY EDWARD J. POLITYLO, COMMANDER, DAV CHAPTER 8, PITTSBURGH, PA., AND SAMUEL RINELLA, ASSISTANT STATE ADJUTANT FOR LEGISLATION AND ADMINISTRATION, DISABLED AMERICAN VETERANS, DEPARTMENT OF PENNSYLVANIA

Mr. **Graffius**. The gentleman to my left is Ed Politylo, Commander, chapter No. 8, DAV Department of Pennsylvania. The gentleman on my right, I think you know real well, Sam Rinella, who is the assistant adjutant for legislation and administration for the DAV Department of Pennsylvania.

Mr. **Edgar**. Thank you. Welcome, gentlemen, we appreciate your coming. In light of the time and the need to have a full opportunity for us to see this center and not spend all of the day here with hearings, we have covered a lot of issues.

We have talked about the State homes, we have talked about the quality and need of care. As I look through your statement, while it is a very comprehensive statement, it does repeat some of the things that have been said by others.

Where possible, it would be helpful if you could summarize your statement, give us the points that may be different from other statements, or underscore your support for your colleagues' comments, and we would appreciate that summary, if possible.

Mr. **Graffius**. Yes, sir.

On behalf of Commander Charles L. Crow, and the 40,000 officers and members of the DAV Department of Pennsylvania, we are grateful to have been given this opportunity to voice our concerns.

We tour the hospitals throughout the State annually, and are represented therein on a daily basis, and certain complaints continue to surface. Generally, they are the same, but in varying degrees.

Problems exist in, one, the way appointments are kept; prescriptions are not always promptly filled, and on occasions, prescriptions have to be substituted due to nonavailability.

Doctor-patient communications are not always clear, because some foreign-born doctors have problems articulating their instructions. Meals are not always hot when served to the patients.

Doctor-nurse retention is a problem due to workload and pay scale competition with the private-sector hospitals.

All veterans need and deserve the very best that we can offer. The average age of a World War II veteran is 63 years old, and as they near normal retirement age, and think in terms of living on a fixed income, they will depend more and more on our VA hospitals.

Radiation exposure is one of the special problems as a result, as a result of testing the bombs.

Our youngest group of veterans are from the Vietnam war, and we are slowly becoming aware of their special problems: Agent orange, post-traumatic stress syndrome, just to name a couple. I ask you, can we honestly deny any veteran help when he requires it?

According to estimates made available, there are some 133,000 disabled veterans in Pennsylvania. As the need increases, so will the figure escalate. Due to the high unemployment rate, and our general economic state, veterans who once had major medical coverage will certainly make more use of VA medical facilities. Again, the workload increases, requiring more staffing and more beds.

Generally, the VA health care system at present is second to none. But we would be remiss if we didn't caution you that the system must keep up with the demands placed on it to be efficient.

One possible alternative would be to provide additional funding to the States for the construction of State-operated veterans' homes, which offer nursing and domiciliary care.

We are proud of what Pennsylvania has accomplished in their renovation of the Pennsylvania Soldiers' and Sailors' Home, located in Erie, and the conversion of a former State hospital to the Hollidaysburg State Veterans' Home located near Altoona, Pa.

The DAV is already on record as opposing any legislative or administrative attempt to allow the Department of Health and Human Services, or health systems agencies, to have any type of role or influence in policy matters relating to the future improvement and/or expansion of the VA hospital system.

All morning, I have been hearing about how additional funding may be procured. One way we could do that is if we could pass legislation that would allow the VA hospitals to procure additional funding where non-service-connected veterans with medical insurance would be charged by the VA for hospital services rendered to them.

That is one alternative.

In conclusion, we would like to thank you for your attention, Mr. Chairman, and also that of your committee, for giving the DAV this opportunity to express our views regarding these matters.

[The statement of Mr. Graffius appears on p. 107.]

Mr. EDGAR. Thank you very much. I want to say a special word of thanks to your national office that does a good job in Washington in trying to keep us informed.

Last year, as chairman of the Education, Training, and Employment Subcommittee, Ron Drach and others spent a great deal of time educating me on issues relating to education and employment.

I would also say that I am a minority voice on the House Veterans' Affairs Committee in support of your last comment. It seems to me that if a veteran is injured out in front of a veterans' hospital and is rushed inside, and happens to have Blue Cross or Blue Shield or some other third-party provider insurance, we ought to be able to recover some of those funds as a way to reduce the cost of veterans' care.

I am not sure that the national service organizations have been very supportive of that in the past. We were able to get a small amendment passed which I introduced to provide for some recovery of that cost, but I think we have a long way to go. There is a lot of resistance to having any obstacle put in the way of providing care, when I think in some instances, we are providing care to veterans who did have third-party insurance and other means of providing for their care in other than veterans' facilities. It could recover some of the costs.

Are there additional questions that my colleagues have?

Thank you very much for your statement today.

Mr. HOAK. Yes, sir, thank you very much.

Mr. EDGAR. Our next witness will be Mr. Meyer Kronberg, National Service Officer, Jewish War Veterans. Meyer, it is a pleasure to have you here, and as you come to the microphone, I invite you to bring your colleague.

Meyer and I worked very closely with Stanley Rosenberg from the Philadelphia area. His influence is very strong among Jewish war veterans, but also in the halls of Congress as he makes sure that my staff understands the views and the wishes of the Jewish war veterans.

I would ask, if you could, to summarize your statement rather than reading it. I know it is a difficult task sometimes, because of the work that you have put into providing the statement, but we are already 1 hour and 15 minutes over the timeframe of our hearing, and we do have two additional witnesses to hear from.

Mr. KRONBERG. Thank you, Mr. Chairman.

I would like to first introduce Sol Katz, our national executive committeeman from this area. I would also like to point out that we had—there are over a dozen people here this morning from our organization who are vitally interested.

We have one of the commanders——

Mr. EDGAR. Will those members stand who are here from the Jewish War Veterans?

Thank you very much for your participation this morning.

Mr. KRONBERG. We only have a handful left, including Al Worksman and Eleanor Worksman, who are both commander and president of 0718, who also represent the 181 and Post 49.

It is very interesting when we talk about care, because one of the people that is going to testify today, and I mentioned this earlier, Mr. Chairman, is David Bernstein. David Bernstein was in one of the best non-VA hospitals in the area, and had real problems with bed sores, et cetera.

We got him into the VA hospital, and within 2 weeks, those bed sores cleared up, and I might mention Mr. Bernstein had everything he needed as far as coverage was concerned, but the delivery of health care just isn't the same outside the VA as it is inside the VA. We are talking about two different worlds.

STATEMENT OF MEYER KRONBERG, NATIONAL SERVICE OFFICER, JEWISH WAR VETERANS OF AMERICA

Mr. KRONBERG. Mr. Chairman. My name is Meyer Kronberg, my position is National Service Officer, Jewish War Veterans of the United States of America.

My office is in the Veterans' Administration regional office, 1000 Liberty Avenue, Pittsburgh, Pa.

I studied veterans' affairs at the American University, Washington, D.C., in 1947, sponsored by the DAV; achieved a degree of national service officer; was assigned to the New York City Regional Office, Brooklyn, New York Regional Office; VARO Chicago, Ill.; then in charge of DAV offices—VARO Buffalo, N.Y.; then VA Center, Wilmington, Del.

I have been a national service officer for Jewish War Veterans in the Pittsburgh, Pa., regional office for the past 12 years.

I know of our good friend in Philadelphia. I have known him for a longer time than that, and we do collaborate.

As a matter of background, I also served in World War II, Africa and Italy. Was with the 168th Infantry as a combat medic; was awarded the Silver Star; have a Purple Heart with an Oak Leaf Cluster.

When we were discharged after World War II, nothing was good enough for the GI. It wasn't long after that when so-called economy groups, who, while advocating unlimited budgets—for example, the Marshall plan—found it convenient to detract and attempt to subtract from benefits to the veteran.

At this point, I wish the records to again show this country's most solemn obligation is to the veteran, his dependents, his widow and his orphan. Nevertheless, the onslaught on benefits was in the making.

Then came Korea and again the flags flew. Then an onslaught on the veterans; and Vietnam and finally, long overdue recognition and continued delays to this date in the proper assessment and need for care for residuals of agent orange. And now, the onslaught on veterans' benefits is in full swing.

Every effort has been made by certain groups who, while endorsing unlimited commitments to organizations like our financial institutions, in my opinion, believe nothing—meaning a big zero—is too good for the veteran.

You know about the cost task force. I would like to know the financial interests of the members of that task force.

As an example, recently VA medical centers were forbidden to provide lunch for veterans who are called in and they have to spend the day at the facility for examinations or workups.

There are exceptions. However, even day care patients are included.

Currently, veterans applying for hospitalizations can be treated to prevent this hospitalization, cannot be seen again if there will be a need for more than four followup visits.

And, of course, therefore, almost all veterans with chronic conditions must be told, "Sorry, we cannot treat you." Posthospital care is limited and must be reviewed by the director or his designee for treatment to continue beyond the year.

The foregoing denials for treatment refer to non-service-connected veterans. Although treatment for veterans age 65 and over may not be affected at this moment and time——

Mr. EDGAR. If the gentleman would yield. We have your full statement in front of us, and most of us have had time to review and read that statement. It might be better for you, as well as the audience to look through and pick out those important points, because the whole statement will be included in the record. It is available to us, and under the pressure of time, it would be helpful if you could just lift out the three or four or five key points that you wanted to make.

And I apologize for interrupting.

Mr. KRONBERG. Thank you, Mr. Chairman.

I refer to the millions of World War II veterans who are going to be desperately in need. And I question whether anything has really been done to provide the needed medical care other than the proverbial lipservice.

My belief is the VA will be totally overwhelmed. Of course, we can always renege.

And, incidentally, as has been said before, applications have gone up from 15 to 21 percent. In Altoona, the figure is 20 percent new applications have no medical insurance.

Now, as we have discussed previously, a real big problem is staffing. Butler, for example, where you are going to be next, or shortly, there are 1.52 people to take care of veterans whereas, the minimal ideal is 2 per patient.

Now, let me give you some figures you haven't heard before. A typical picture for 60 patients is 14 people in the day, 6 in the p.m., and 6 at night.

However, this must be spread over a 7-day period. Therefore, at any given time, or on any given day, rather, there are 3 RN's, plus 5 nursing assistants, or 8 daytime people for 60 patients, who, in addition to everything else, need to be bathed, clothed, feeded, need medical attention.

There is also need of assistance for these sicker patients for assistance in their toilet needs.

This is the reason you were told this hospital needs 90 additional FTS.

Now, you know, there isn't sufficient time for this staff to even talk to patients, and it is therefore these helpless patients may as well be a convict, because they just lie there helplessly.

We know of cases where they were so short of help—and I am going off my written report now—that we had man here, there are others like him, who are absolutely helpless. They only have movement from the neck up, and yet these men, because of the shortages, at times, were only approached when it came time to feed them.

There is supposed to be time, at a minimal of every 2 hours, that when their turn—and the only attention they got was when it was time to feed them, and they were not gotten out of bed for almost a week a time, and that is what these shortages mean, Mr. Chairman.

Now, they didn't mention the fact that an NP medical center, where visits are restricted to the initial and four followup visits, we have, in practically all cases, created an impossible situation.

Now, another area that hasn't been covered, we should not overlook a byproduct of staffing shortages also creating an undue hardship when examinations for rating purposes are requested. Delays of 60 days are not unusual from the time an examination is requested, the date of this examination report is received by the VA regional office.

There are instances of prolonged delays lasting months. This, in many cases, creates a severe hardship on the veteran who is looking forward to an increase in compensation which is dependent on the result of this examination.

There are further problems created when an examination must be returned to the doctor, not having had sufficient time to examine the veteran. Some examinations being conducted in 5 minutes without the doctor either following the Physicians' Manual for Examinations, or because of the time pressure, ignoring same.

Hospital facilities need adequately supplied pharmacies. There are even shortages of pharmacists. Budgets over these most recent years have created poor economics. With the cost of medication, drugs and medical supplies increasing 15 to 25 percent a year, the Veterans' Administration receives increases of 4 to 5 percent a year. This is more than unreasonable.

Let me give you another example of problems. As you have heard, there continues to be areas in need of new construction, modernization of structures and equipment.

A sharp example is the lack of proper freezers in diatetics at the Veterans' Administration at Butler. Although criticized by the VA Commission of Accreditation, the scheduled replacement of freezers for food storage—that is in the freezers for food storage—was to be for 1982, moved up to 1983, and now apparently will be in 1984.

Another area which hasn't been adequately covered, without research, medicine comes to a standstill and slides backward. The Veterans' Administration medical research is world reknown, its researchers having been awarded two Nobel Prizes.

In the VA Medical Center in Oakland, research also needs space. There are about 11 people, physicians, some who are forced to work at the university, which also has space problems.

In the past, the VA research has been hurt by cuts. It is to be noted, researchers at the VAMC in Oakland found the answer to legionnaire's disease and include outstanding individuals: Dr. Starzel, liver transplants; Dr. Hakala and Dr. Rubertis, doing work on cancer of the colon; and Dr. Sacks, working on multiple myeloma, et cetera.

Research is also being conducted on nephrology, pulmonary diseases, and problems of the aged. Outstanding research scientists are attracted, and additional space is therefore acutely needed.

Now, talking about geriatric facilities, there is room for expansion in Erie, Butler, with N.P. geriatric facilities at Highland Drive, and general geriatric facilities at Oakland, with additional facilities in Altoona.

Now, Mr. Chairman, referring to a bill which you are familiar with, we are talking about an increase of $9.50 and $16.90 in the nursing home care. Now, we don't believe this is adequate, and we believe it helps, but we respectfully submit, will there be more funds? Maybe the States could be encouraged to build these sorely-needed nursing homes.

In summarizing, I can speak from personal experience about patient care, having been hospitalized most recently at the VAMC in Oakland, and from discussions with in and outpatients at other VA hospitals in this area, in spite of the problems created by fewer dollars, resulting in reduced staffs, space, medication and material shortages, all personnel and leadership, both lay and professional, deserve accolades for the kind and the quality of medical services, both and present.

I wish to thank you, Mr. Chairman, and this committee, for your time and the invitation to appear before you.

[The statement of Mr. Kronberg appears on p. 111.]

Mr. EDGAR. Thank you very much for your very comprehensive statement, and I share your concern about the amount of money being provided for per diem rates for the State homes.

We are in a little bit of a bind in Washington with the high deficits. We are in a little bit of a bind in the fact that the administration did not come forward with any increase in per diem rates.

It was not until we heard from the National Association of State Home Directors that we actually realized that there was a substantial need, and we were horrified when we saw how little commitment the Federal Government has put in for such a great service.

The bill which I have introduced is a compromise bill that will provide at least moving toward that 30-percent Federal commitment to State homes. I think it ought to be higher, in the 40-percent area. I am not certain, and I say this as a partisan statement, under this administration, there aren't going to be any additional funds for any program. It is not that they don't have a commitment to veterans, but they have made their commitment to $1.6 trillion defense budget, at the same time, they gave up $750 billion of tax resources through the large tax cut 2 years ago.

And that means that all of the programs that are over on the discretionary side of the budget, are under great pressure and great attack. I don't think we will see any additional funding levels in that area unless we provide it ourselves.

But I appreciate the earnestness of your statement. I, too, wish that the commitment to the State homes was far greater than it is. Unfortunately, I don't think that is going to occur, at least in the near future. And so, the bill that I have introduced, I believe, should be supported as aggressively as possible, because there is such a great need in the nursing home and State home area.

I don't have any additional questions, except to commend you for your work and your leadership and to thank you for swelling our audience by bringing so many of your members here.

I just recently received the Man of the Year Award from the Philadelphia Area Jewish War Veterans, and the plaque that they gave me, including a second plaque which contained a small Torah, helped me to understand the real commitment of the Jewish community to its veteran population.

I am probably the only member who came today who can speak and read Hebrew. I spent 3 years in theological school studying the

Old Testament, and so I have a great deal of affection for your organization. And I respect your presence here today.

Mr. KRONBERG. Mr. Chairman, our commitment is such that we are not only the oldest active war veterans in this country. However, my Post 718 is the first veterans organization to build senior citizens housing, which is in Monroeville, totally subsidized.

Mr. EDGAR. Very good.

Thank you for your statement today.

Mr. EDGAR. Our next witness is Mr. David Bernstein, national director of the Paralyzed Veterans Association for the Tri-State chapter, Paralyzed Veterans of America.

Mr. Bernstein?

You deserve a Medal of Honor for your patience today in waiting to testify. It is not easy to have that kind of patience, and I truly appreciate your willingness.

I noticed from your statement that it is brief, so I won't repeat my comments about abbreviating your statement. Would you introduce your colleague this morning, who I think is a very important part of your organization.

STATEMENT OF DAVID S. BERNSTEIN, NATIONAL DIRECTOR FOR THE TRI-STATE CHAPTER, PARALYZED VETERANS OF AMERICA

Mr. BERNSTEIN. Well, she is not only a colleague, she happens to be my wife and my assistant.

Mr. EDGAR. Very good.

Mr. BERNSTEIN. And we thank you very much for coming to Pittsburgh to visit us, and we hope you are enjoying your stay here.

Mr. EDGAR. Very good.

Mr. BERNSTEIN. Mr. Chairman and members of the subcommittee, I, David Bernstein, representing the Tri-State chapter, Paralyzed Veterans of America, would like to express my gratitude for allowing me to give our views on VA hospitals and health care.

First, let me review what PVA is all about. PVA is a service organization formed in 1948 and chartered by Congress in 1971. We are made up of over 11,000 veterans who have been disabled with a spinal cord injury or dysfunction.

Tri-State chapter is one of 34 chapters located throughout the United States, also including Puerto Rico and Mexico. Our national headquarters is now located on 18th Street in Washington, D.C. It is the first architecturally barrier-free building in the United States.

Our organization is dedicated to promote quality health care in VA hospitals. We also render trained administrators in legislative, advocacy, and veterans' affairs.

Before going on with my statement, I would like to say I am not here to be critical but hope to make you aware of existing problems. Let us not forget that the VA Administrators have done a commendable job, considering the cutbacks in the budget.

Some of the major complaints veterans have passed on to me are as follows:

One; there are too many doctors who are in training and not enough permanent ones. As a result, you get conflicting opinions and constant change.

Two; patients detained for hours should be subsidized for their meals. These meals were eliminated through a ruling from the VA Administration.

Three; there are not enough nurses on the floors where specialized care is needed.

Four; there is a communication problem because of the many foreign doctors and a language barrier.

Five; not enough doctors are present during the clinic hours.

We have always maintained the good relationship with the hospital administrator and his staff. I am sure some of these complaints can be remedied in the future.

The now-existing Spinal Cord Injury VA Hospital in Cleveland is being investigated as to whether it will remain open.

If the decision is to close that facility, it has been recommended that Pittsburgh be an alternate site. It would be beneficial to many veterans with spinal cord injuries in the Pittsburgh and surrounding areas.

In conclusion, in the past, this committee has always recognized and compensated veterans for their service and sacrifice. Like this committee, PVA is only concerned about getting the best health care for all veterans.

Mr. Chairman and members of the subcommittee, this concludes my statement. I will be glad to answer any questions that I can.

Thank you.

[The statement of Mr. Bernstein appears on p. 115.]

Mr. EDGAR. Thank you very much for your statement.

I want to assure you that as chairman of this subcommittee, one of the areas we are investigating during the course of this year is the whole specialized area of spinal cord injury centers.

And I want to spend some time in those centers throughout the country and take our committee to a number of them through the course of this six-region hearing process this year.

I know there is a shopping list of complaints, are complaints that others have had, and I would have only one question of you, and that would be: Are there some specialized problems that paralyzed veterans have that we should be specifically aware of, in terms of long-term care for paralyzed veterans?

Mr. BERNSTEIN. Well, I think I could use myself as an example, with my wife. There are many veterans with spinal cord injuries who are put into hospitals, who would certainly be taken care of better at home and provided financially by the VA to take care of that patient at home.

Putting them in an institution is not the answer. Because, you see, here is a good example, myself, by participating in a veterans' organization, that I feel I am doing something for the spinal cord injured veterans. And that is a good example, what you are seeing right now, my wife and myself.

Mr. EDGAR. That is very helpful. I think the whole home care area is one we haven't gotten into today, both for spinal cord and paralyzed veterans, but also it is an option rather than the nursing care or some of the other facilities that veterans provide to recognize some unique needs in in-home care.

And I thank you for that statement.

Mr. **Bernstein**. Could I add one more thing, Mr. Chairman?

I would like to give you an invitation to your committee and yourself, if any one of them has not seen our new headquarters that has just been dedicated in February, in Washington, D.C., please call. We would love to have you.

Mr. **Edgar**. I think most of our members have had a chance, at least had the invitation to go and see it. We have all had an invitation to go and see it, and I hope that all of us will take advantage of it in Washington. It is a great center.

Thank you again for your patience and your testimony.

Mr. **Bernstein**. Thank you.

Mr. **Edgar**. Our final witness of our hearing will be Mr. William—before I introduce him, let me just tell you that the other members are touring the hospital and visiting other facilities, so they haven't gotten lost. They are simply out having an opportunity to focus in on the veterans' needs.

Our next witness will be Mr. William Dzurko, national service officer of AMVETS, and a library advocate, and I have the pin on my jacket. So, I just wanted that to be noted for the record.

In fact, it is the second time I have received a library pin. Last week, the librarians were in Washington for a national conference, legislative conference, and some libraries from Delaware County—librarians—came by to visit, and shared with me the new logo, and I appreciate your providing a pin for each of the members of the committee.

STATEMENT OF WILLIAM DZURKO, NATIONAL SERVICE OFFICER, AMVETS, PITTSBURGH, PA.

Mr. **Dzurko**. Chairman of the committee, I am happy to have this opportunity to present an item of vital interest to the AMVETS of the western district of Pennsylvania Library Service in the Veterans' Administration Medical Centers.

Perhaps it could be considered a presentation on the lighter side. Basically, we want to bring to the attention of the committee the importance of the Library Service to the long-term health care needs of the hospitalized veteran.

To allocate to the Veterans' Administration Medical Centers' directors ample funds for the staffing of all health care physicians.

Ironically, in the Thursday evening issue of the McKeesport Daily News, dated April 21, 1983, a column titled, "In Library Week, Readers Have Their Say."

Quoting Karen Miller, woman's page editor:

> I believe a library is as important to a community as, say, a hospital; to feed the brain, to escape from daily problems and for useful recreation. I believe we could not consider a community civilized without one,

perhaps says it better than any thoughts I may have had on the subject.

At this time, I would like to add the following:

Our organization, the AMVETS western district of Pennsylvania, and with the generous help of VFW Post 303, have become the god-fathers of library service in the six Veterans' Administration Medical Centers in our area.

Also, the two State veterans' homes are being provided with moneys to help in their special projects.

At Aspinwall Medical Center, we have supplied a visual tech reading machine, mobile bookcases, and reading room racks in the lounges, a page turner will be purchased in the very near future.

Presently, we hope to completely renovate the patients' library in the Oakland Veterans' Administration Medical Center. This will include drapes, carpets, furniture, and needed bookcases.

The money is not large in comparison to the budgetary figures of the hospitals as a whole. However, to raise $7,000 is not exactly an easy task in the economic situation existing in Pittsburgh, Pa.

We in our area will continue to help in every way possible, but we want assurances that the special equipment being purchased will be available to the hospitalized veteran on a regular basis.

If the committee plans on touring either or both University Drive Medical Center or Aspinwall, I hope they will spend a few moment in the libraries. We are so proud of the part the godfathers are playing in their rehabilitation.

Our thanks to you this afternoon for this opportunity to present our thoughts on the library service as a long-term humanistic quality in our American society.

Thank you.

[The statement of Mr Dzurko appears on p. 117.]

Mr. EDGAR. You are to be commended. I think you have a sense that comes through in your testimony that providing health care, both long- and short-term health care, is providing that care to the whole person, and not just in terms of medical gadgets that are attached to the human being. The spirit and the mind are also important to treat, in the course of that hospital stay.

Providing service through the library system is a significant and important role in health care and health delivery. Your statement clearly makes that point, trumpeted loud and clear with a nice pin attached to it.

So I want to commend you for your taking the time to put the statement together. I can assure you that we are visiting all three of the medical facilities in this region, and that some few of our members, dividing up in the different tours, will have an opportunity to stick their head in and talk with some of the patients who are using the library facilities in this region.

And your statement will ring loud and clear in our ears, and I want to commend you for that.

Mr. DZURKO. Thank you, sir.

Mr. EDGAR. Thank you very much.

The hearing is about to come to an end. I want to thank our staff, and particularly want to thank the staff of this particular facility for extending to us the use of this room and its facilities for this congressional hearing.

We made history today by bringing so many Members of Congress to the Pittsburgh area to listen to witnesses. We spent a little extra time here in the hearing process, which is very valuable. We now plan to spend the rest of the day, and all day tomorrow, visiting all five of the facilities in western Pennsylvania.

I hope that you have found this a productive session, and it has been for me. I am looking forward to completing these 2 days and starting on the process of a long journey through the six medical regions to really get a better idea and a better handle on what the quality and quantity of health care should be over the next 5, 10, 15, and 20 years in the veterans' health care system.

This hearing now stands adjourned.

[Whereupon, the subcommittee adjourned, to reconvene subject to the call of the Chair.]

APPENDIX

K. LEROY IRVIS
THE SPEAKER

HOUSE OF REPRESENTATIVES
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

APR 14 1983

April 11, 1983

The Honorable Robert Edgar
2442 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Edgar,

This is in response to your correspondence dated April 7, 1983, regarding the oversight hearings being conducted by the House Veterans' Affairs Sub-committee on Hospitals and Health Care.

I consider your invitation to make the opening remarks of welcome and concern a great honor. Unfortunately, since the legislature will be in session on April 25, I will not be able to attend the hearing.

As indicated in your letter, I am very interested in the welfare of all Pennsylvania veterans, particularly those confined in or receiving assistance from VA Medical Centers. These hearings would, I am certain, be of great benefit to me as we consider legislation pertaining to veterans later this session, but as previously stated, my schedule does not permit me to attend.

Thank you for this very kind invitation and I sincerely regret that I am unable to accept the same.

Sincerely,

K. Leroy Irvis

KLI:dee

STATEMENT OF HON. DOUG WALGREN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. **WALGREN**. Mr. Chairman, ladies and gentlemen, distinguished speakers, good morning.

I want to thank you for this opportunity to participate today in this very important hearing on the quality and quantity of health care being provided to eligible veterans in my home area of Western Pennsylvania.

I commend the Subcommittee for holding this hearing here in Pittsburgh within the shadow of some of this nation's finest medical facilities.

It is very gratifying to me that the Subcommittee is examining the adequacy of available health care for veterans in this region which is so proud of its tradition of service to our country.

As we gather here today to exchange information, I believe that it is time we reverse the thinking of some that veterans need only be honored through their participation in patriotic ceremonies. For, while we properly remember and celebrate the valor of the men and women who have served to ensure our freedom, we must also move forward to remedy the immediate day-to-day and long-term health problems facing the young and aging veterans.

It seems to me that so much of the talk in Washington lately has focused on the need for more and more expensive weapons systems to the exclusion of the human factor involved.

While the debate on all this continues, I believe that the essential element in maintaining a strong defense is being overlooked. It is afterall, the men and women who serve who ultimately make the defense system work. Without these dedicated individuals, each of us might not now enjoy the freedom that we know.

I am disturbed that this Administration is failing to live up to a commitment that must be made to train and maintain a sound and healthy soldier and to ensure that the veteran soldier receives all appropriate health care needed after his or her termination from military service.

We are all too familiar with the experience of the recent veterans of the Vietnam war who continue to fight to receive adequate treatment for themselves and their families because of exposure to agent orange. It is time that the Reagan Administration realized that this problem is a very real one that must be dealt with now.

But, the broader health problem that lies ahead for all veterans is really one of having the necessary care and facilities for an increasingly aged population. Because aging veterans often have special problems related to their service years, it is critical that our universities and medical centers here in Pittsburgh and elsewhere emphasize the study and advancement of geriatric medicine in the core curriculum of their medical schools. Special attention must also be given to training the necessary support staff to handle the special needs of the aged veterans in care facilities. It is not enough that existing facilities and practices seem to be handling the veterans in need of care.

The sheer weight of demographics strongly suggests that right now and for the forseeable future, the need for veterans health care will increase dramatically. I am committed to meeting this need and call upon all the parties involved to begin now to plan for the future. I will not support increased military-related expenditures that short-change personnel and do not reflect increased appropriations for the care and expansion of health care for veterans.

Today we are sorely in need of accurate information on present and future health needs of veterans. It is of the utmost importance for these studies to be carried out expeditiously so that persons and families suffering from service-related disabilities and health problems can begin to receive the treatment that the government owes them. This task cannot be accomplished in a piecemeal fashion, but rather must be part of a coordinated effort drawing on the strengths of the medical profession in facilities such as we have here in Western Pennsylvania. I urge this Subcommittee to approve the necessary authorization of funds so that we can meet the goal of adequate and appropriate health care for every eligible American veteran.

It is important that we also match our efforts in medical research with a strong commitment to building and rebuilding veterans hospitals to meet the expected increase in the number of patients seeking access to these facilities. Even if we succeed in our efforts to treat the problems of younger veterans and those unique to the geriatric veteran, our efforts will be in vain without the determination to expand and modernize veterans facilities both here and across the country.

I call upon the Subcommittee in its efforts to upgrade and improve the available health services for all veterans to remember and pursue this goal of appropriate facilities with increased capacity.

I want to thank you again for the opportunity to be here today and for your kind attention to my remarks. I am impressed with the Subcommittee's attention to the needs of the veterans here in Western Pennsylvania, and I look forward to working closely with all of you in this area.

STATEMENT OF
C. R. PAULK
REGIONAL DIRECTOR
MID-ATLANTIC REGION
DEPARTMENT OF MEDICINE AND SURGERY
VETERANS ADMINISTRATION
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

April 25, 1983

Mr. Chairman and Members of the Subcommittee:

I am pleased to have the opportunity to discuss the Veterans Administration, Department of Medicine and Surgery provision of health services to eligible veterans in Western Pennsylvania.

Department of Medicine & Surgery health services are provided to eligible veterans in Western Pennsylvania primarily through a network of five medical centers: Pittsburgh - University Drive (including its Aspinwall extended care division); Pittsburgh - Highland Drive; Altoona; Butler; and Erie. In addition to the 28 counties in Pennsylvania, these medical centers, along with the one in Clarksburg, W. Va., form our Medical District #5. It serves 66 counties in the tri-state Ohio/Pennsylvania/West Virginia area, a map of the district service area is attached. Therefore, my remarks will be in reference to Medical District 5 as a whole.

Currently this District has an estimated 837,000 veterans. It is authorized 2,392 hospital beds and 405 nursing home care beds. The district has a combined medical center employment ceiling of 4,261 FTEE and a combined FY 83 budget of over $158 million. So far during FY 1983 the number of inpatients treated is 6.5% over planned levels for the Pennsylvania facilities and the number of outpatient visits is 11% over planned levels. Occupancy rates are averaging 81.5% with a few facilities over 90%. Service to female veterans represented about 1.5% of the FY 82 workload; however, an increase of 20% in inpatient admissions and 40% in outpatient visits of female veterans has been noted so far this year over last year's average monthly rate. Agent Orange examination requests appear to have levelled off. However radiation exposure claims and examinations are expected to increase.

Planning projections for this Medical District, developed as part of the Medical District Initiated Planning Process (MEDIPP), showed a 7% decline in the number of veterans but a major shift in over 65 age veteran from 11% to 26% by 1990. This means district planning must address the problems of the Aging Veterans. This includes redefining missions, converting underutilised acute care beds to extended care or nursing home care beds, improving ambulatory care and outpatient facilities at several centers, and initiating or improving other services to the elderly veterans. The first MEDIPP plan is now in the approval process within the Agency.

These planning efforts may result in consolidations of certain programs and functions. Relocation of some outpatient functions, addition of alcohol detoxification services and initiation of geriatric day care programs are other proposals for cost containment and improved services that are being considered.

Construction of a consolidated laundry to service the greater Pittsburgh area medical centers will further assist in controlling costs.

More than $22.0 million of fire/safety, direct patient care, and patient support improvements are underway in this district or have recently been completed. Over $48 million dollars of clinical improvements and outpatient/ambulatory care improvements are about to get underway or are programmed for Clarksburg, Altoona, and University Drive. Approximately $30 million dollars of environmental and patient privacy improvements are programmed for Erie and Highland Drive. The District is in the preliminary planning stages for a total rejuvenation of the Aspinwall facility anticipated to cost $110 million dollars to support its key role of serving the aging veterans. Expenditures of $10.7 million dollars in FY 83 and the proposed FY 84 budget for consolidation of laundry and warehousing will both limit cost and improve efficiency. Therefore, if the 5-Year Agency Construction plan for the district is fully implemented, more than $220 million dollars would be expended in Medical District 5 between 1983 and 1987. This kind of expenditure is necessary to provide for the influx of female veterans, the increasing needs of the aging veterans, and to maintain safe, economical, and adequate environments for all eligible veterans in this district.

Maintenance and Repair is an ongoing requirement. More than 6.3 million has been allocated for FY 83 for maintenance and repair projects and an additional $3.5 million has been recommended for distribution by means of the recently passed "Jobs Bill". As can be well appreciated when maintaining 25 to 60 year old buildings, the cost is a major consideration. Significant funds are required just to maintain the status quo.

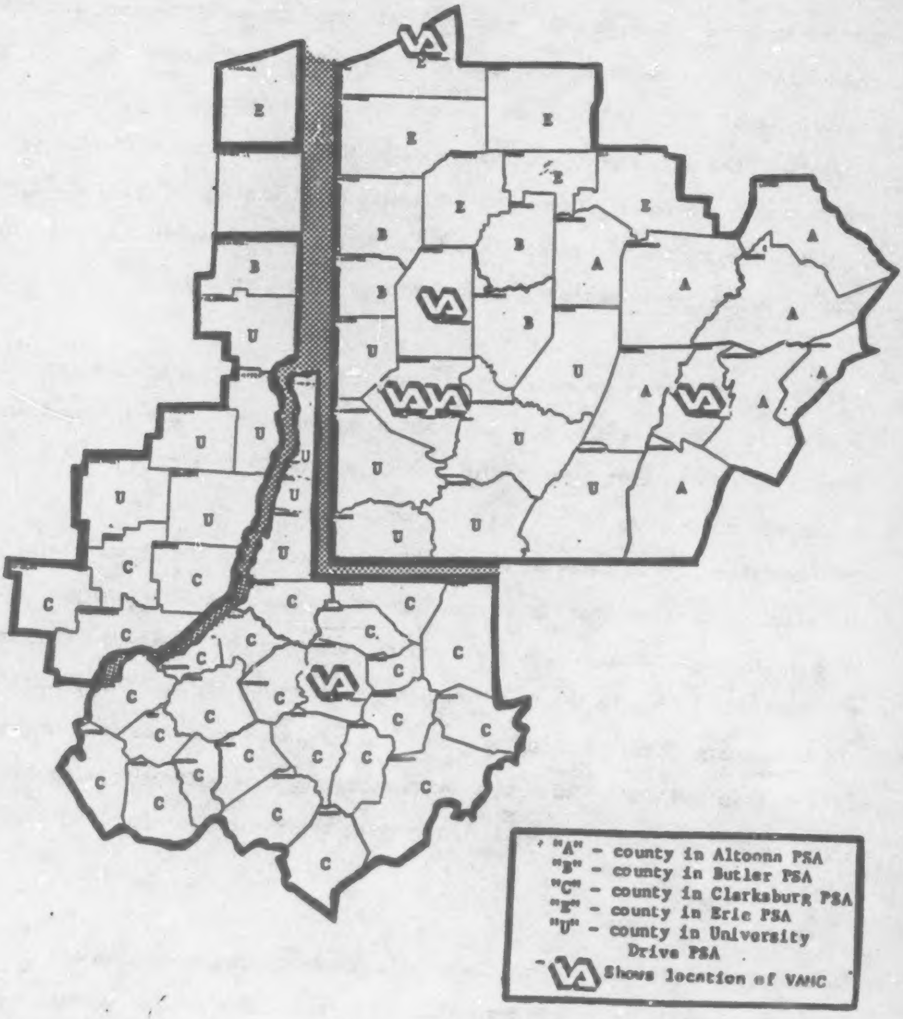
Resources for planned workload and the temporary workload condition being experienced are still adequate. Staffing overall is generally adequate to meet planned workload. However, the urban medical centers are experiencing staffing problems with registered nurses, specialty physicians, and certain technologists. While salaries are not competitive in certain technologist categories, the main impediment appears to be the fringe benefits offered by non-VA health providers. Often, non-VA health providers are offering employees significant educational packages, and fully paid medical/hospital insurance with equal or better coverage than available through federal plans.

Despite the ever present demand for properly using scarce resources at more or less static funding levels, several programs and activities have improved our overall ability to meet patient care needs. An example of such a program is the Automated Data Processing Program (ADP) which is scheduled for rapid implementation. University Drive and Altoona Medical Centers already have installed small operational computers for certain administrative and patient care support functions. All six medical centers have been reviewed and sized for computers to handle the core functions of Pharmacy, Medical Administration, and Laboratory. Tentative delivery of these computers should begin in January 1984 at Erie VAMC, with University Drive receiving a very large unit in July 1984. The other facilities will be receiving their units within about 270 days of ordering.

Sharing agreements exist where financially advantageous or services are otherwise unavailable to the district. University Drive Medical Center is also serving at the request of the Department of Defense as the Coordinating Facility for the Military/Civilian Contingency Hospital System (MCCHS) and the close consortium effort of Medical District 5 is promoting a steadily increased sharing effort between these 6 VA medical centers.

This concludes my statement, Mr. Chairman, I or my colleagues will be pleased to respond to any questions that you or members of the Subcommittee may have.

MEDICAL DISTRICT 5


"A" - county in Altoona PSA
"B" - county in Butler PSA
"C" - county in Clarksburg PSA
"E" - county in Erie PSA
"U" - county in University Drive PSA
Shows location of VAMC

BEST COPY AVAILABLE

Medical Center
University Drive C
Pittsburgh, PA 15240

Veterans
Administration

April 28, 1983

In Reply Refer To: (646/11)

Honorable Robert W. Edgar
House of Representatives
2[illegible]52 Rayburn House Office Building
Washington, D. C. 20515

ATTN: Mr. Richard Fuller

SUBJ: Congressional Subcommittee Hearings,
Veterans Affairs Committee on Hospital and Medical Affairs
Pittsburgh, Pennsylvania - April 25, 1983

1. In regards to your request for information during the recent hearings held in Pittsburgh, Pa., VA Medical Center, University Drive submits the following data on physician turnover at this facility for Fiscal Year 1982:

Physician Status	Turnover Rate
Full-time	13%
Part-time	10%

2. If additional information is required, please telephone me (FTS-8-726-3200).

THOMAS A. GIGLIOTTI
Medical Center Director

STATEMENT OF
WAYNE L. HARTMAN, Ph.D.
TEAM LEADER, PITTSBURGH & MONROEVILLE VET CENTERS
READJUSTMENT COUNSELING SERVICE
DEPARTMENT OF MEDICINE AND SURGERY
VETERANS ADMINISTRATION
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

April 25, 1983

Mr. Chairman and Members of the Subcommittee:

I am pleased to have the opportunity to discuss the provision of readjustment counseling to Vietnam Era veterans and their families in Western Pennsylvania.

Provision of readjustment counseling in this area began with the opening of the Pittsburgh Vet Center at 954 Penn Avenue on April 1, 1980. Since that time, this center has seen over two thousand veterans and their families and has provided a range of psychological readjustment counseling services. This center has been, and remains, the hub of counseling services to Vietnam veterans in Western

Pennsylvania and, for almost two years, was the only location that provided treatment for veterans suffering from the effects of Post-Traumatic Stress Disorder. With the expansion of the Veterans Administration's Outreach Program, a second location in the Pittsburgh area was established with the opening of a satellite Vet Center at 4328 Old William Penn Highway, Monroeville, Pennsylvania, on December 7, 1981. This expansion also added Vet Centers in Harrisburg, Pennsylvania, and Morgantown, West Virginia, which made readjustment counseling services more available in some of the more rural areas of Western Pennsylvania. A further step in this direction came with the implementation in 1982 of the contract/fees program, which made readjustment counseling services available in smaller communities, such as, Altoona, State College, New Castle, Erie, Wheeling, West Virginia, and Youngstown, Ohio. [While there have been some difficulties in launching the contract/fees program in terms of attracting qualified health service providers, and the program remains less than ideal in its cost and the time requirements placed on the Vet Center staff, the program has partially achieved the goal of making these services available to all Vietnam Era veterans, regardless of their location.]

It has been an illuminating and challenging opportunity to work first-hand with the problems of this area's Vietnam Era veterans over the past three years, and to witness the significant changes that have occurred in that relatively brief time span. When the Pittsburgh Vet Center first opened it was quickly deluged with veterans, especially those who had seen combat in Vietnam, who were angry and disillusioned with the system that had sent them to war and then tried to forget them. They saw little hope, trusted virtually no one, suffered the pain of Post-Traumatic Stress Disorder in silence and isolation, and, as a group, were fragmented and scattered. They had not talked with anyone about their war experiences, and, in fact, had gone to great lengths not to even think about them. Symptoms of Post-Traumatic Stress Disorder were frightening, debilitating, and, for the most part, unheard of by the professional community from which a few of them had sought help. Only three short years ago the situation faced by many such veterans appeared very bleak indeed. It is not at all surprising that alcohol and drug abuse, unemployment, divorce, and suicide were prevalent and compounding problems. But in the span of only three years there has been a remarkable change, both in the attitudes of the veterans themselves and in the society that had tried to ignore them. An upsurge of interest in the Vietnam War, as evidenced by the proliferation of documentaries, movies, and novels, as well as research evidence that uncovered and explained the existence of Post-Traumatic Stress Disorder, created a new focus of interest on this substantial segment of our society. One of the most significant roles in all of this was played by the Disabled American Veterans, who laid the groundwork, funded the research, and pioneered the concept of a network of community-based, self-help centers for Vietnam Era veterans - one of which was located in Pittsburgh. From this prototype, the Veterans Administration's Outreach Program and the Vet Center network was launched. The impact has indeed been great. We have watched dysfunctional men turn into productive citizens; seen a fragmented and isolated group turn into a powerful political force which has dramatically made itself felt and heard. We have seen local organizations of veterans spring up, such as in the Pittsburgh area - the Vietnam Veterans, Incorporated, which have done a tremendous job in recapturing the sense of pride, camaraderie, and accomplishment, which are essential elements of psychological recovery from a wartime experience. Perhaps the most important and significant event, however, and one that seemed initially impossible a short time ago, was the dedication of a national memorial to Vietnam veterans in Washington, D.C. on November 13, 1982, and the week-long National Salute to Vietnam Veterans that preceded it. No longer are Vietnam veterans ignored or neglected. They have displaced the stigma of an unpopular war; they have risen above society's guilt and efforts to forget; and they have shown that with only a bit of help and understanding they have the capacity to overcome the pain and turmoil of Post-Traumatic Stress Disorder. While we have come through a period of change through which the Outreach Program itself has evolved and undergone refinement, there remains the task of reaching and serving thousands of veterans who still suffer, as well as continuing to provide for the additional needs of our current clients.

In directing my comments more specifically to the Western Pennsylvania area, and the Pittsburgh and Monroeville Vet Centers in particular, I can report to you that over 2,263 Vietnam Era veterans and their families have been seen to date, for a total of 11,812 visits. The centers offer individual, group, and family counseling services to any eligible Vietnam Era veteran regardless of combat experience. For those veterans suffering from Post-Traumatic Stress Disorder, we have found group therapy to be very effective in reducing symptoms and enhancing interpersonal effectiveness. The centers currently offer a choice of four such groups a week, two of which have run continuously for over three years. In addition, spouses and families of eligible veterans are also included in the treatment process. The centers offer wives' groups at various intervals as well as ongoing marital and family counseling. Other therapeutic groups for veterans focus on enhancing interpersonal and vocational potential. Vet Center counselors also provide personalized individual counseling for specific problems, vocational and career guidance, crisis intervention, and social support services. They develop and maintain a network of community relationships to aid in identifying clients and providing referral for specialized services. To date, program statistics indicate an overall average of 5.2 visits per veteran client. The total staff of seven for both centers (which include a team leader, four outreach specialists/counselors, and two clerical positions) currently see an average of 253 separate clients per month, and the centers continue to attract new clients at the rate of an average of 85 veterans per month. As a point of comparison, the Pittsburgh Center's workload has increased from 1805 veteran visits in FY1980, to 2950 in 1981, to 3210 in 1982. During FY82, comparing the total budget for both centers - including staff salaries - with the total case workload, the centers are providing readjustment counseling services to this area's veterans for an approximate cost of slightly under $25 per visit.

In short, Mr. Chairman, I believe that the Vet Centers in Western Pennsylvania have played a vital role in helping to transform the plight of this area's Vietnam Era veterans into a much more positive and hopeful scenario than was the case three years ago. The centers continue to provide quality readjustment counseling services to veterans and their families and do so on an efficient and cost effective basis. While this success has not been without problems and setbacks, we have come a great distance in providing a model for effective outpatient service delivery for the VA system. What remains to be done is to assure that every veteran in the country that needs help - regardless of how geographically isolated - has access to readjustment counseling services and is made aware of their availability.

That concludes my statement, Mr. Chairman. I will be pleased to answer any questions you or members of the Subcommittee may have.

THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

TESTIMONY OF DONALD F. LEON, M.D., DEAN
SCHOOL OF MEDICINE, UNIVERSITY OF PITTSBURGH
APRIL 26, 1983

In many ways the medical care available to veterans in the greater Western Pennsylvania community is exemplary. Obviously, there are some small deficiencies and I will elude to them later. These could be improved were it not for the constraints related to federal budget limitations. However, by way of explanation, let me point out in the beginning, the context in which the University Drive Veterans Administration Medical Center is situated.

First of all, it is a full-fledged University teaching hospital with all of the advantages which accrue from that status. The University of Pittsburgh School of Medicine stands as one of the acknowledged leaders in teaching, research and clinical service in the United States. We have 700 full-time faculty, 1,400 volunteer faculty, 545 first professional degree medical students, 85 graduate students in the sciences basic to medicine and 650 advanced physician trainees in the various medical specialties. Our overall academic budget is just short of $100 million per year and our sponsored research budget is over $30 million per year. We are part of a University with national stature and which is a member of the prestigious Association of American Universities. This, as you know, is an association of the

50 leading major universities in the United States. In addition, our medical school is a member of the distinguished Medical School Consortium, the other members of which are Harvard, Yale, Columbia, Cornell, the University of Pennsylvania, Duke, the University of Rochester, Case Western Reserve, the University of Chicago, Stanford, Johns Hopkins and Vanderbilt.

Our Medical School conducts virtually all of its education, care and research in our own health sciences center, The University Health Center of Pittsburgh. The members of the Health Center are Children's Hospital of Pittsburgh, the Eye and Ear Hospital, Magee-Womens Hospital, the Montefiore Hospital Association of Western Pennsylvania, Presbyterian-University Hospital, and the University of Pittsburgh with its 6 health sciences schools and Western Psychiatric Institute and Clinic. The VA Medical Center is an affiliated member of the Health Center and it would be a full member if not for federal regulations which prohibit that type of contractual relationship.

We have 3 adult general teaching hospitals for our Medical School, Presbyterian-University, the VA Medical Center and Montefiore Hospital. Our housestaff and students are trained within these 3 institutions and rotate from service to service between these hospitals during the academic year. It is obvious from these relationships that the University Drive Veterans Administration Medical Center is a major and integral part of our medical education, research and clinical care comple

I believe that the veterans who reside in the Western Pennsylvania community have benefited from this relationship. The vast majority of physicians who staff the University Drive Hospital are members of the full-time faculty of the University of Pittsburgh School of Medicine. Our relationship is somewhat unique in that these Veterans Hospital physicians may aspire to and achieve University tenure as tangible evidence of the integral relationship and value in which the Medical School holds this affiliation. Housestaff and medical students provide care and receive high quality instruction at the VA Hospital as well as other hospitals in the Health Center. As tangible evidence of the importance of our academic affiliation, Dr. Stanley Geyer, the Chief of Staff at the VA Hospital, is Assistant Dean in the School in addition to being a full-time faculty member.

The University Drive Hospital, and the patients it serves, benefit from having its medical staff made up of high quality academic physicians who have competed successfully for full-time faculty appointments in one of the outstanding medical schools in this country. The housestaff and students have similar intellectual and professional strength. As a result of the expertise of the staff-faculty physicians, the hospital has become a very highly regarded tertiary care referral center for VA Medical District #5 about which you will hear more later. Our staff-faculty physicians have been supportive of and deeply involved in the Medical District #5 MEDIPP (the Medical District Initiated Program Planning Process) which seeks to improve care and efficiency throughout this entire district.

The patients referred to the University Drive Hospital also benefit from a free exchange of medical school faculty who are assigned directly to the School of Medicine, as well as to other hospitals in the University Health Center. By this mechanism the expertise of the 74 VA staff is expanded many fold.

It is obvious that patients who are cared for in this environment enjoy access to the very finest medical specialists and physicians in training. In addition to this, the hospital, in recognition of its important role as a Dean's Committee academic medical center, continues to provide expert management, strong nursing and patient support services and excellent referral relationships with other hospitals within the Health Center.

Having heard these strengths, one would ask where the deficiencies might be. Let me try to express those in general terms.

It is obvious to all that federal budget constraints have developed over the past few years. During this very same period, the demand for medical expertise has escalated in this community. The housestaff and faculty physicians have taken on a vastly expanded load, not in terms of numbers of patients but in terms of advancing complexity of illness. This can be seen in a statistical review of the experiences of the highly specialized services such as open heart surgery, renal dialysis, organ transplantation, and so forth. The effects of federal budget constraints have been felt in limitations in nursing and support staff numbers and limited ability to expand housestaff support to handle the increased severity of illness. The VA Central Office has been good enough to identify our problems and has managed to help us whenever possible, but frankly, the resources there are limited and we still have need of some improvements in staffing and equipment to keep pace with the ever increasing complexity of illness which we experience.

It is obvious that the hospital and patients are not the only beneficiaries of this relationship. The School of Medicine benefits as well, by having top quality training opportunities at the University Drive Hospital for medical students and housestaff. In addition, the affiliations offer the opportunity for us to expand our faculty through the VA staff mechanism and thereby to improve our overall strength, research enterprise and national reputation. These types of benefits are very important to a leading strength medical school such as ours.

The Dean's Committee, which I chair personally, also holds responsibility for the VA Medical Center at Highland Drive. As you know, this is a long-term neuropsychiatric unit which is just now beginning to develop strong academic relationships in psychiatry with the School of Medicine. I believe that the Medical School stands to benefit greatly through the development of these relationships. These somewhat embryonic relationships have been extraordinarily successful thus far.

As a final comment for the record, I wish to emphasize that in my estimation strong cooperative Medical School--Veterans Hospital relationships are one important foundation of top quality care for veterans. It is through this mechanism that distinguished staff-faculty and vigorous, highly motivated housestaff can be attracted to offer the highest level of specialized medical care to veterans. The tertiary hospital referral system for Medical District #5, as contemplated in MEDIPP, may prcve exemplary and in this manner, the strength and talents of our veterans administration faculty will become available to the entire medical district.

I wish to express my gratitude for having been invited to offer this testimony before your committee and I would be happy to answer any questions.

MARSHALL UNIVERSITY
OFFICE OF THE VICE PRESIDENT FOR HEALTH SCIENCES
AND DEAN OF THE SCHOOL OF MEDICINE
HUNTINGTON, WEST VIRGINIA 25701

STATEMENT BY ROBERT W. COON, M.D., VICE PRESIDENT FOR HEALTH SCIENCES AND DEAN OF THE SCHOOL OF MEDICINE, MARSHALL UNIVERSITY, TO THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE OF THE HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS.

Pittsburgh, Pennsylvania April 25, 1983

Both Marshall University and the Veterans Administration can take pride in the impact the Marshall University School of Medicine has had on health care for veterans and other citizens. Like the other so-called "541 schools", Marshall has undertaken to change a sleepy domiciliary into an active general hospital. For the Huntington, West Virginia, VA Medical Center, the affiliation has meant improved physical facilities, more physician specialists, staff increases and new services.

Although the VA had provided area veterans with health care for nearly 50 years, the hospital was not really considered a part of the local medical community before the Medical School affiliation. During the term of this grant, the Medical Center has become an integral part of the community's medical care system, and works side by side with community hospitals on a regular basis in planning and coordinating services.

The ripple effects of the School of Medicine reach through essentially all of West Virginia and into Kentucky and Ohio. The school has affiliations with Huntington's two major hospitals and with Huntington State Hospital. Its physicians' practice group provides "walk-in clinics" for adults and children plus specialty and subspecialty care -- some not available elsewhere in the area.

The School of Medicine has ties with more than 40 communities in West Virginia. Most full-time clinical faculty members have outreach responsibilities, sometimes staffing clinics in outlying areas or working with rural clinics to provide consultation services. Through two requirements designed to expose students to rural practice, fourth-year medical students spend nearly 10 work years per year serving in West Virginia communities outside Huntington.

The School of Medicine has a strong research program for a school its size, as well as a continuing medical education program whose events have drawn physicians from 23 states.

This is in addition to our work to give our 158 students the desire to practice in rural areas and equip them with the special skills this kind of practice requires.

The School has developed a continuing medical education program and seven residency programs (family practice, internal medicine, pathology, pediatrics, psychiatry, surgery and obstetrics/gynecology).

The School of Medicine also enhances Marshall University as a whole, helping in the recruitment of faculty and students, and encouraging a "climate of inquiry", i.e. research.

We have accomplished all this despite the fact that we are not living in the best of times for developing a new medical school because of the recession, the reduction in available education and research funding and the specter of a potential oversupply of physicians. National pressure has been to decrease enrollments rather than develop new schools or increase enrollments. However, we wholeheartedly believe the School's widespread contribution to the area more than justifies its existence.

We are particularly pleased with the results of our affiliation with the Veterans Administration Medical Center. Prior to fiscal year 1976, veterans needing care even in common specialties such as cardiology and urology were transferred to other VA medical centers. By 1980, then Medical Center Director A. Paul Kidd was able to report to Central Office that the affiliation had "brought about vast improvements in the quality and scope of medical care offered veterans." He said the affiliation was influential in providing specialty care where little existed before 1976 in cardiology, endocrinology, hematology/oncology, pulmonary medicine, urology, vascular surgery, surgical oncology, gastroenterology, infectious disease and clinical pharmacology.

The affiliation has been effective in developing a quality program which continues to improve, resulting in enhanced care for veterans.

The major problem we face is that the recession and increasing demands have made it difficult for the VA to live up to its commitments to support the process of upgrading the VA Medical Center. The resources just are not available without pulling money away from other equally needy VA hospitals.

The Huntington VA Medical Center is coping with a double surge of patients, partially because of the recession and partially because the center is offering more and better services than it could in the past, including the addition of key specialists to provide a full spectrum of clinical services. The number of laboratory tests increased from 266,000 in 1977 to more than 1 million in 1982, up 277 percent; x-ray exams rose from 9,600 to 16,000, up 67 percent; and outpatient pharmacy prescriptions increased from 110,000 to 227,000, up 106 percent.

The increasing age of the veteran population compounds the problem, since the older veterans need more and increasingly sophisticated care.

All these factors put pressure on the School and the Medical Center to increase services, and the economy makes it extraordinarily difficult to do so.

We recognize that constricting resources nationally have made it difficult for the VA to meet our expectations in program support and, more importantly, people support.

As a new School and a developing Medical Center, we are too late to benefit from the "special programs" funding previously available in the VA. Such programs must now be developed by reallocation of local resources, which in our case are already inadequate.

Nevertheless, to effectively meet our veterans' needs we desperately need increased personnel and operating support, the planned 70-bed addition, and computerized data processing for the hospital.

Although we understand the Agency has plans to provide basic or core computer equipment for each VA hospital, we are not yet assured of receiving such equipment. Actually the lack of computerization in VA hospitals is not only a severe handicap to the operation of the hospitals, it is also a disgrace in today's age of technology.

We urge Congress to take special cognizance of the unique requirements of Medical Centers affiliated with the Marshall University School of Medicine and the other "541 schools."

In conclusion I recommend that Congress appropriate funds specifically designated to fulfill the commitments to the VA hospitals affiliated with the new and developing so-called "541 schools". Without such support we in the schools cannot fulfill our commitment to the VA and to the citizens of our states.

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SUB-COMMITTEE CHAIRMAN ON
VETERANS HOMES

HOUSE OF REPRESENTATIVES
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

STATEMENT OF

HONORABLE JOHN F. CORDISCO
PENNSYLVANIA HOUSE OF REPRESENTATIVES
CHAIRMAN, SUBCOMMITTEE ON VETERANS HOMES
HOUSE MILITARY AND VETERANS AFFAIRS COMMITTEE

TO

SUBCOMMITTEE ON HOSPITALS & HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS, U. S. HOUSE OF REPRESENTATIVES
PITTSBURGH, PENNSYLVANIA
APRIL 25, 1983

MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE ON HOSPITALS & HEALTH CARE, COMMITTEE ON VETERANS AFFAIRS, U. S. HOUSE OF REPRESENTATIVES. IT IS INDEED A HONOR TO APPEAR BEFORE YOU TODAY TO PRESENT AN OVERVIEW ON THE OPERATIONS OF THE VETERANS HOMES WITHIN PENNSYLVANIA AS WELL AS OUR FUTURE REQUIREMENTS AND RECOMMENDATIONS.

The Commonwealth of Pennsylvania provides its veterans the service of two veterans homes. One is located in the beautiful rolling hills of Blair County in the environs of Altoona at Hollidaysburg, the county seat.

Our second home is located on the shore of Lake Erie in the northwestern portion of the City of Erie.

Both homes have on-going construction programs to improve or increase the physical plants. Hollidaysburg Veterans Home has 202 nursing care beds and 179 domiciliary beds, however, it has a program goal to reach a total of six hundred beds by 1986. Four hundred and twenty five of the beds will be for nursing care and 179 domiciliary beds.

The Pennsylvania Soldiers' and Sailors' Home located in Erie presently has a new seventy-five bed nursing care unit and a one-hundred bed domiciliary unit which has been modernized to meet all of the most recent advancements in home style living accomodations for its residents. The home provides not only domiciliary care, but has a limited number of more intensive personal care beds for those veterans requiring care below the level of nursing care.

The primary objective of the Veterans Homes Programs is to provide a homelike environment that allows the highest level of resident care available. Accordingly, a full range of services including full time resident physician, nursing care, social services, physical therapy and therapeutic recreation activities, is available to help each resident reach the fullest use of his mental, physical and social capacities.

Our homes are inspected by the Veterans Administration and surveyed by the Commonwealth's Department of Health annually to insure that we meet both Commonwealth and Veterans Administration health care standards and staffing patterns.

Veterans are admitted by applications procured from the local County Directors of Veterans Affairs or Service Officers of National Veterans Organizations.

Since both homes are normally fully occupied a waiting list for each level of care is maintained based upon the date the application is received by the Department of Military Affairs. Both homes provide skilled and intermediate nursing care as well as domiciliary or personal care. The domiciliary waiting list moves reasonably fast. Unfortunately, the nursing care beds may require a year or more waiting time, which is comparable to Veterans Administration Nursing Care Facility waiting lists.

The operating costs of our two homes this fiscal year are estimated at $11.8 million with funding sources as follows: State Funds, $8.3 million; Federal Funds, $1.15 million; Resident Fees, $1.8 million and Aid and Attendance Payments for Nursing Care patients estimated to be $437 thousand. The proposed budget for the 1983-84 fiscal year is $14 million with the state share being $9.6 million, Federal $1.7 million and residents fees $2.1 million.

In 1977, in response to recommendations by the House Military and Veterans Affairs Committee, The Department of Military Affairs implemented a maintenance fee program requiring the residents of our State Veterans Homes to contribute toward the cost of their care based on their ability to pay. This fee permits residents to retain a minimum of $100 per month plus 20% of all remaining income from all sources.

I might add that in the event H.R. 1645, sponsored by you, Mr. Chairman, is enacted into law, and based upon our current resident Population, Pennsylvania would be eligible to receive approximately $457 thousand more in federal funds, thus, enabling us to reduce our state share by an equal amount.

I would now like to discuss the VA/State Construction Program.

Since 1974, $5.443 million has been spent on improving the Erie Soldiers and Sailors Home with the Commonwealth financing 57% of these improvements. Further, $6.9 million has been expended converting the Hollidaysburg State Hospital to a Veterans Home, with the state funding 46% of the conversion costs. We have requested an additional $5 million in federal funds to complete the Hollidaysburg project. However, with the current $60 million backlog in VA construction grants it means it may be four to six years before we can expect these funds even though we have $2 million in state construction funds available.

There is much criticism by private nursing home administrators of VA and states building nursing home facilities - they allege they can build them cheaper. The problem is in standards. In Pennsylvania private for profit nursing home construction ranges from a low of $22,000 to a high of $36,000 per bed with the mean at a range of $24,500 to $27,000 per bed. The VA construction cost range from a low of $76,000 to a high of $150,000 per bed. State consturction ranges from $30,000 to $50,000 per bed. In Pennsylvania our

CONSTRUCTION COSTS FOR THE 75 BED NURSING CARE UNIT IN ERIE WAS $30,872 PER BED (NO KITCHEN INCLUDED AND ADMINISTRATIVE SPACE INCLUDED). THIS WAS A NEW BUILDING SEMI-DETACHED FROM THE ADMINISTRATIVE AND DIETARY BUILDING.
AT HOLLIDAYSBURG UTILIZING THE CONCEPT OF CONVERTING AN EXISTING FACILITY OUR COSTS WERE:

A. RUSH HALL - 202 BED NURSING CARE UNIT - $19,780 PER BED
B. NEAL HALL - 179 BED DOMICILIARY UNIT - $16,409 PER BED
C. PROGRAMMED SOMMER HALL 225 BED NURSING CARE UNIT - $19,041 PER BED

THESE UNITS DO NOT INCLUDE A DIETARY UNIT. THE RENOVATIONS OF THE DIETARY UNIT ARE PROGRAMMED AT $1.1 MILLION AND THE BOILER PLANT IMPROVEMENTS $279 THOUSAND. IF WE PRORATE THESE COSTS TO EACH BED IT WOULD INCREASE THE PER BED COST BY $2,290. THE AVERAGE NURSING CARE BED CONSTRUCTION COSTS WOULD THEN BE $21,000 AND THE DOMICILIARY $18,000.

CURRENT PLANNING FOR A THIRD HOME IN EASTERN PENNSYLVANIA IS TO CONSTRUCT A HOME WITH 200-350 NURSING CARE BEDS AND 75-150 DOMICILIARY BEDS. BASING THE COSTS ON OUR EXPERIENCES AT HOLLIDAYSBURG AND CONSIDERING EASTERN PENNSYLVANIA AS A HIGH-COST CONSTRUCTION AREA THE COST FOR A 275 TO 500 BED FACILITY WOULD RANGE FROM $23,000 TO $30,000 PER BED IF AN EXISTING FACILITY WERE USED. THE STATE COSTS AT 35% WOULD RANGE FROM $2.2 MILLION TO $4 MILLION. HOWEVER, UNDER CURRENT VA FUNDING LIMITS, PENNSYLVANIA CANNOT EXPECT TO RECEIVE SUPPORT TO CONSTRUCT THIS VITALLY NEEDED HOME FOR AT LEAST 7 YEARS, A HOME THAT WOULD SUPPORT THE NEEDS OF OUR VETERANS IN THE MOST POPULOUS AREA OF THE COMMONWEALTH. ACTION MUST BE TAKEN TO INCREASE THIS FUNDING LEVEL IF THE VARIOUS STATES ARE TO CONTINUE PROVIDING CARE FOR OUR AGING VETERANS - CARE THAT IS RIGHTFULLY THE DUTY OF THE FEDERAL GOVERNMENT TO PROVIDE, BUT ONE THAT THE STATES ARE READY AND WILLING TO ASSIST IF THE PROPER SUPPORT WAS FORTHCOMING.

THIS COMPLETES MY STATEMENT. I'LL ATTEMPT TO RESPOND TO ANY QUESTIONS YOU MAY HAVE.

DEPARTMENT OF PENNSYLVANIA
Veterans of Foreign Wars
OF THE UNITED STATES

Testimony for presentation before Subcommittee on Hospitals and Health Care
Chaired by The Honorable Bob Edgar, M.C.
VA Medical Center, Highland Drive, Pittsburgh, PA., - April 25, 1983

I am John Boyd Coates, Jr., M.D., and I represent here today the Veterans of Foreign Wars of the United States, Department of Pennsylvania. State Commander Thomas J. Dougherty has asked that I appear before this important Committee today, chaired by the Honorable Bob Edgar. It is my distinct pleasure to do so.

I am a retired Brigadier General, U. S. Army, Medical Corps. It has been my honor to have been elected annually, since 1975, as Surgeon of the Department of Pennsylvania, Veterans of Foreign Wars of the United States and, as such, I have made it my high priority to be as well informed as possible as to the medical care afforded the veterans of the United States. I might add that I consider it a high privilege to have been elected to the office of Surgeon General of the National Veterans of Foreign Wars of the United States and to have served that organization in that capacity in 1979-1980.

Since 1975, on a yearly basis or more often at times, I have had the opportunity to visit the ten (10) various medical centers operated by the Veterans Administration in the great Commonwealth of Pennsylvania, spread across our land, as they are, from Pittsburgh to Wilkes-Barre and from Erie to Philadelphia. I have utilized the many opportunities thus afforded to discuss the medical care rendered to our veterans with the doctors, nurses, administrators, and many other dedicated personnel who are associated with these medical centers. And, with much more than casual interest, I have seen at first hand during these nine (9) years the actual services being rendered to our veterans.

Furthermore, the more than 200,000 members of our State V.F.W. and its Auxiliary have given me valuable input and helpful information regarding matters coming to their attention, in addition to their own personal observations.

Further, it has been my privilege, since about 1975, to be a member of the Dean's Committee of the Coatesville VA Medical Center Jefferson Medical College of Philadelphia, which Committee is Chaired by Paul Fink, M.D., the distinguished Professor and Chairman of the Department of Psychiatry and Human Behavior at Jefferson. The function of this Committee serving as it does, and meetng monthly, to advise, assist and monitor the clinical care of patients, and the programs of research and education at the Coatesville

Medical Center has sharpened my conviction of the worthwhileness of close affiliation between our VA medical facilities and the medical colleges and universities nearby. It is good for both. And, it strengthens the capabilities of both for the betterment of the patient.

So much for backgroud information.

The State of Pennsylvania believes in and firmly supports the medical activities of the Veterans Administration. On the whole, we believe that the VA is providing medical care to veternans which is equal to and perhaps better, than would be provided in the local civilian community. This varies, of course, with localities. Those VA facilities which are affiliated with large universities and medical schools are staffed largely by the university personnel. The capability for and the calibre of medical service in those hospitals is unexcelled anywhere. In addition, it should be pointed out, the availability and use of consultants in the various specialities at other VA medical facilities is helpful in maintaining a high level of medical/surgical care in other VA hospitals.

I would like to say a few words about the personnel staffing of VA medical centers. Gneerally speaking, it is my impression that the number of doctors assigned are adequate in numbers and professional competence. This is not to say that there is any surplus. There is not. And, in some hospitals on certain services, additional physicians could be gainfully utilized. The Old Leech Farms Hospital and the Lebanon Hospital come to my mind as possible recipients of additional psychiatrists to assist with the workload, and rehabilitation processes.

From my observations, likewise, it is my opinion that VA medical centers could utilize additional nursing personnel. Their numbers are borderline and this applies to all within my cognizance. I would like to see them increased. In so doing, the staffing would be more compatible with that found in the better community or university hospitals.

The management of VA medical facilities is on the whole to be commended.- These are, on the whole, dedicated, hardworking, intelligent and skilled individuals. They are understanding of the many complex problems dealing with medical care in the broad sense. They are understanding of the problems of veterans and the problems with which veterans must contend. They are cooperative with the veterans' organizations and they appreciate the assistance which the latter offer. And they must and do contend with many outside intrusions into their domain of responsibilities. They are cost-conscious but they wish their patients to have that which is required for best possible care. They do their best to maintain as modern and safe and clean installation as possible. They are generally cooperative and understanding of the needs of the professional staff. The presence of modern equipment in the VA hospitals attests to their concern in that area.

In recent years, there has been a trend in VA medical facilities to treat patients on an outpatient basis whenever possible. The civilian community hospitals and civilian physicians are doing likewise. It makes sense. It is much less expensive. The VA has had to adjust accordingly. And, this has required alterations within the hospitals both in structure, professional staffing, and in other ways. This is a good trend. I have yet to find an inpatient who would not rather be at home than in a hospital away from his family and loved ones. Where indicated and possible, outpatient care for veterans should be encouraged, bearing in mind that each case must be based on its own professional requirement.

In closing, I would like to offer a few comments regarding nursing homes, as well as domiciliary facilities. In recent years, we have seen a great need for the nursing home facility, in particular, in the civilian community, as well as for the use of veterans. One has only had to have the experience of having a member of his family living in such home for him to realize the problems connected with same -- not to mention the unGodly cost of such experience. While the Veterans Administration has activated and/or constructed some of these nursing homes or residences, they are limited in capacity. There are usually extensive waiting lists for admission. The VA should have a greater capacity in the way of nursing homes and domiciliaries.

Much to the credit of the Commonwealth of Pennsylvania, two such domiciliary homes and nursing homes for veterans are operated by the State. One is located in Erie and the other is located in Hollidaysburg. Another Home is critically needed in Southeastern Pennsylvania. At the present time there is no such State facility in that area. The Governor of Pennsylvania is well aware of this matter and of this need. At the Erie installation and at Hollidaysburg, extensive alterations and/or new construction has taken place at both of these Homes during the past 2 - 3 years so that compliance with all codes is in effect. And, we are now proud of these Homes. At each, there is an Advisory Council to the Governor and to the State Adjutant General. These Councils are composed of competent, dedicated veterans representing a broad scope of veterans organizations and who are dedicated to the welfare of veterans. Altho the Councils are advisory only, they meet quarterly at the respective Homes and review the activities, the personnel staffing, the budget requirements, the medical care given, the recreation and general care provided, the maintenance of buildings and grounds,etc., and we are not reluctant to make recommendations where and when indicated. I am President of the Advisory Council at the Hollidaysburg Home on which is also the senior member of the Pennsylvania Senate, as well as a member of the House of Representatives of the State.

These State Homes, as you may know, are supported financially by the Commonwealth of Pennsylvania, by the Federal Government, and by the residents themselves. The Department of Pennsylvania VFW urges the Federal Government to raise the very minimal support which it currently gives to these Homes. With the various States hard-pressed as they are throughout the country, it would appear only reasonable to expect a higher percentage of Federal funding for the care of our Nation's veterans than now given by the Federal Government. Your Committee,Sir, could be most helpful in obtaining that increase for which all concerned would be appreciative.

Thank you for the opportunity to present these views and observations before your Committee.

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DISABLED AMERICAN VETERANS

DEPARTMENT OF PENNSYLVANIA

HOUSE VETERANS AFFAIRS SUBCOMMITTEE

ON

HOSPITALS AND HEALTH CARE

DONALD C. GRAFFIUS, DAV,
JUDGE ADVOCATE
DEPT. OF PENNA.

Good morning, I am Donald Graffius. I am the Judge Advocate for the Disabled American Veterans, Department of Pennsylvania, and I have been requested to appear before you and present our views.

On behalf of our Commander Charles L. Crow and the 40,000 Officers and Members of the Disabled American Veterans, Department of Pennsylvania, we are grateful to have been given this opportunity to voice our concerns.

We tour the hospitals throughout the state annually, and are represented therein on a daily basis and certain complaints continue to surface. Generally they are the same, but in varying degrees. Problems exist in the way appointments are kept, prescriptions are not always promptly filled, and on occasions prescriptions have to be substituted due to non-availability. Doctor-Patient communications are not always clear, because some foreign born doctors have problems articulating their instructions. Meals are not always hot when served to the patients. Doctor/Nurse retention is a problem due to work load and pay scale competition with the private sector hospitals.

All veterans need and deserve the very best we can offer. The average age of a World War II veteran is 63 years old, and as they near normal retirement age, and think in terms of living on a fixed income they will depend more and more on V.A. Hospitals. Radiation exposure is one of their special problems, as a result in testing the bomb. Our youngest group of veterans are from the Vietnam War, and we are slowly becoming aware of their special problems, Agent Orange, Post Traumantic Stress Syndrome, just to name a couple. I ask you can we honestly deny any veteran help when he requires its.

According to estimates made available, there are some 133,000 disabled Veterans in Pennsylvania. As the need increases so will the figure escalate. Due to the high unemployment rate, and our general economic state, veterans, who once had major medical coverage will certainly make more use of V.A. medical facilities. Again the work load increases requiring more staffing and more beds.

Generally the V.A. healthcare system at present is second to none, but we would be remiss if we didn't caution you that the system must keep up with the demands placed on it, to be efficent.

One possible alternative would be to provide additional funding to the states for the construction of State Operated Veterans Home, which offer Nursing and Domiciliary Care. We are proud of what Pennsylvania has accomplished in the renovation of the Pennsylvania Soldiers and Sailors Home, located in Erie, and the conversion of a former state hospital to The Holidaysburg State Veterans Home located near Altoona, Pennsylvania. The conversion has complied with all V.A. Regulation in the Life/Safety Code.

The D.A.V. is already on record as apposing any Legislative or Administrative attempt to allow The Department of Health and Human Services, or Health Systems Agencies to have any type of role or influence in policy matters relating to the future improvement and/or expansion of the V.A. Hospital System.

In conclusion, we would like to thank you for your attention Mr. Chairman, and also that of your committee, for giving the Disabled American Veterans this opportunity to express our views regarding this matter.

ADMISSION DATA
VETERANS HOMES
PERIOD: From 3/1 to 3/31/83

NC - Nursing Care
DOM - Domiciliary

	BEDS AUTHORIZED BY VA		BEDS OCCUPIED		BEDS ** VACANT		NEW ADMISSIONS		DISCHARGES		WAITING LIST		APPLICATIONS RECEIVED & PROCESSED APPARENT LEVEL OF CARE *			ASSIGNED RESIDENTS IN ACUTE HOSPITAL CARE		ASSIGNED RESIDENTS ON FURLOUGH OVER 96 HOURS	
	NC	DOM	NC	DOM	NC	DOM	NC	DOM	NC	DOM	NC	DOM	NC	DOM	NOT ACCEPTED Physical/Statutory	NC	DOM	NC	DOM
PENNSYLVANIA SOLDIERS' and SAILORS' HOME	75	100	67	51	8	49	4	3	3 (CTB)	0	60	0	4	4		3	1	3	2
	(175)		(118)		(57)		(7)		(3)		(60)		(8)			(4)		(5)	
Total NC: 73																			
Total DOM: 54																			
Grand Total Assg: 127																			
HOLLIDAYSBURG VETERANS HOME	202	179	103	107	99	72	9	11	5	2	85	26	11	9		4	2	2	4
Total NC: 109	(381)		(210)		(171)		(20)		(7)		(111)		(20)			(6)		(6)	
Total DOM: 113									2-CTB 3-A	(A)									
Grand Total Assg: 222																			
Total NC: 182	277	279	170	158	107	121	13	14	8	2	145	26	15	13		7	3	5	6
Total DOM: 167	(556)		(328)		(228)		(27)		(10)		(171)		(28)			(10)		(11)	
Grand Total Assg: 349																			

REMARKS:
59% Beds Filled
61% NC Beds Filled
57% DOM Beds Filled
63% Auth. Assigned
3% On Furlough
2.8% Acute Care Hospital

*Level of care determined by admissions committee at each home subsequent to a review of medical history and pre-admission examination.

**At least two beds are kept vacant at each home for emergency isolation and transfer of domiciliary residents whose health disintegrates to a point where they need nursing care. Domiciliary residents will always preempt applicants on the waiting list. In some cases because of exigencies and prior coordination with the VA Medical Center Administrator the emergency beds are filled for a short period.

Applications not accepted: Physical (M) mental health (psychotic) or (C) contagious disease Statutory: (NV) non veteran, (I) exceeds income limitation, (DG) dishonorable discharge.

Discharges: (V) voluntary, (CTB) ceased to breathe, (D) disciplinary. (A) Administrative

***Home in process of filling newly authorized beds.

PA S&S Home
72% Auth. Assigned
90% NC Beds Filled
51% DOM Beds Filled
67% Agg. Beds Filled

HVH ***
58% Auth. Assigned
51% NC Beds Filled
60% DOM Beds Filled
58% Agg. Beds Filled

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Jewish
War
Veterans OF THE UNITED STATES OF AMERICA

MEYER KRONBERG
National Service Officer

April 25, 1983

The Honorable Bob Edgar
U.S. House of Representatives
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, D.C. 20515

Dear Congressman Edgar:

My name is Meyer Kronberg and my position is National Service Officer, Jewish War Veterans of the United States of America, my office is in the Veterans Administration Regional Office, 1000 Liberty Avenue, Pittsburgh, PA 15222. Studied veterans affairs at the American University, Washington, D.C., in 1947, sponsored by the D.A.V. Achieved the degree of National Service Officer and was assigned to the New York City Regional Office, Brooklyn, New York Regional Office, VARO Chicago, Ill., then in charge of the D.A.V. offices VARO Buffolo, New York then VA Center Wilmington, Delaware. Have been a National Service Officer for the Jewish War Veterans in the Pittsburgh, PA, Regional Office for the past twelve years.

Served in World War II, Africa and Italy. Was with the 168th Infantry as a combat medic, was awarded the Silver Star and have a purple heart with an oak leaf cluster.

When we were discharged after World War II, "Nothing was good enough for the GI". It wasn't long after that when so-called economy groups, who while advocating unlimited budgets for example, The Marshall Plan, found it convenient to detract and attempt to subtract from benefits to the veteran.

At this point I wish the records to again show, this Country's most solemn obligation is to the veteran, his dependents, his widow, and his orphan. Nevertheless, the onslaught on benefits was in the making.

Then came Korea, and again the flags flew then again an onslaught on veterans' benefits, then Vietnam, and finally long overdue recognition and continued delays to this date in the proper assessment and need for care for the residuals of Agent Orange. And now, the onslaught on veterans' benefits is in full swing.

Every effort has been made by certain groups who while endorsing unlimited commitments to organizations like our financial institutions, in my opinion, believe nothing, meaning a big zero, is too good for the veteran. You know about the Cost Task Force. I would like to know the financial interests of the members of that Task Force.

As an example, recently VA medical centers (hospitals) were forbidden to provide lunch for veterans who are called in and may have to spend the day at the facility for examinations or workups. There are exceptions; however, even day-care patients are included.

Currently, veterans applying for hospitalization and can be treated to prevent this hospitalization can not be seen again if there will be a need of more than four (4) follow-up visits, and of course, therefore almost all veterans with chronic conditions must be told sorry we can not treat you. Post hospital care is also limited and must be reviewed by the director or his designee for treatment to continue beyond one (1) year. The foregoing, denials for treatment, refer to non-service connected veterans. Although treatment for veterans age 65 and over may not be affected at this time and moment, those who will be hurt the most is the Korean and especially the Vietnam veteran.

Now let's look at that magic age 65. Millions of World War II veterans now average 61 and the tidal wave of veterans in need has just begun. Within the next few years, the needs for outpatient, hospital, and nursing home care will be like a tidal wave when compared to the needs, in terms of numbers, as they exist today. We have 29,882,000 veterans today; 4,127,000 65 years and over; 11,582,000 being World War II veterans. In 1985 there will be 5,154,000 veterans over 65 and by the year 1990 there will be 7,688,000 veterans who will have attained age 65. It is my contention, while the VA has acknowledged these figures, I question whether anything has really been done to provide the needed medical care other than the proverbial lip service. My belief is the VA will be totally overwhelmed. Of course, one can always renege.

We only need to look at the currently increased demands created by the hard economic times and the "older" veteran. Applications by the veterans who never used the VA before have gone up from 15 to 21 percent. In Altoona, the figure now is 21 percent, new applications, who now have no medical insurance.

A critical area in VA medical care is staffing. Butler, for example, has 1.52 verses the ideal of over 2 per patient. VAMC Highland Drive, for example, has patients who are helpless and semi-helpless, and with 15 to 20 patients for one RN. A typical picture, for 60 patients is 14 people in the day, 6 in the P.M., and 6 at night. However, this must be spread over a 7 day period. Therefore, on any given day, there are 3 RNs plus 5 nursing assistants, or 8 daytime people for 60 patients. In addition to bathing, clothing, feeding, and medical attention, there is also the needed assistance for these sicker patients to assist them in their toilet needs. This hospital has a critical need for 90 additional F.T.S., for their nursing service . These veterans and especially older veterans should have a nursing staff with sufficient time to talk with them. Otherwise, these patients especially the helpless individuals may not be much better off than a convict.

Also, in an N.P. medical center where visits are restricted to the initial and 4 follow-up visits to prevent hospitalization, we have, in practically all cases, created an impossible situation.

At this time it is interesting to note our VA medical facilities do receive overwhelming praise from patients. A major factor, for example in Oakland, is the mental health staff who render emotional support of such value that one can not really evaluate the enormous health benefits contributing to recovery.

We should not overlook, a by-product of staffing shortages also creating an undue hardship when examinations for rating purposes are requested. Delays of 60 days are not unusual from the time an examination is requested to the date this examination report is received by the Veterans Administration Regional Office and there are instances of prolonged delays lasting months. This, in many cases, creates a severe hardship on the veteran who is looking forward to an increase in compensation which is dependent on the result of this examination. There are further problems created when an examination must be returned, the doctor not having sufficient time to examine the veteran. Some examinations being conducted in 5 minutes without the doctor either following the Physician's Manual for Examinations, or, because of the time pressure, ignoring same.

Hospital facilities need adequately supplied pharmacies. There are even shortages of pharmacists. Budgets over these most recent years have created poor economics. With the cost of medication, drugs, and medical supplies increasing 15 to 25 percent a year, the Veterans Administration receives increases of 4 to 5 percent a year. To say this is more than unreasonable, is an understatement.

There continues to be areas in need of new construction and modernization of structures and equipment. A sharp example is the lack of proper freezers in diatetics at the VAMC in Butler. Although criticized by the Veterans Administration Commission of Accreditation, the scheduled replacement of the freezers for food storage was to be for 1982, moved to 1983, and now apparently will be moved to 1984. After many years with veterans in the numerous clinics, at times sitting on the floors for lack of space, VAMC Oakland has now received some relief with funds for new construction.

Without research medicine comes to a standstill and slides backwards. The Veterans Administration's medical research is world renown, its researchers having been awarded 2 Nobel prizes. In the VA medical center in Oakland, research also needs space. There are about 11 people, physicians, some who are forced to work at the university which also has space problems. In the past, VA research has been hurt by cuts. It is to be noted, researchers at the VAMC in Oakland found the answer to Legionnaires disease and include outstanding individuals; Dr. Starzel, liver transplants; Dr. Hakala and Dr . D. Rubertis doing work on cancer of the colon; and Dr. Sacks working on mutiple myeloma, etc. Research is also being conducted on Nephrology, pulmonary diseases, and problems of the aged. Outstanding research scientists are attracted. Additional space is therefore acutely needed .

Although medical district 5 under the watchful and encourging eye of Mr. Gigliotti has addressed most problems, action at this time should be instituted on a crash basis if we are to do more than render lip service to the older veteran.

There is room for this expansion in Erie, Butler, with N.P. geriatric facilities at Highland Drive, and general geriatric facilities at Oakland with additional facilities in Altoona.

This state has veterans homes with nursing and domiciliary facilities. If additional funding were available, it would become more equitable to expand these facilities. It is therefore urged H .R. 1645 98th Congress 1st session be passed. In view of the acute need for nursing home, domiciliary, and geriatric care, the money referred to in this bill, "$9.50", "$15.00", and "$15.90" we respectfully submit would be helpsul; however, is not adequate.

In summarizing, I can speak from personal experiance about patient care, having been hospitalized most recently at the VAMC in Oakland, and from discussions with in and out-patients in other VA hospitals in this area.

In spite of the problems created by fewer dollars, resulting in reduced staffs, space, medication, and material shortages, all personnel and leadership, both lay and professional, deserve accolades for the kind and quality of the medical service both past and present.

I wish to thank you Mr. Chairman and this Committee for your time and the invitation to appear before you.

Sincerely,

Meyer Krohberg
National Service Officer

MK/ayo

TRI-STATE CHAPTER
PARALYZED VETERANS OF AMERICA
Chartered by Congress

STATEMENT OF

DAVID S. BERNSTEIN, NATIONAL BOARD OF DIRECTORS

REPRESENTING

TRI-STATE CHAPTER, PARALYZED VETERANS OF AMERICA

BEFORE

THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

OF

THE HOUSE COMMITTEE ON VETERAN' AFFAIRS

CONCERNING

THE VETERANS CARE IN V.A. HOSPITALS AND HEALTH CARE

APRIL 25, 1983

Mr.Chairman and Members of the Subcommittee, I, David Bernstein, representing Tri-State Chapter, Paralyzed Veterans of America, would like to express my gratitude for allowing me to give our views on V.A. Hospital and health care.

First let me review what P.V.A. is all about. P.V.A. is a Service Organization formed in 1948 and chartered by Congress in 1971. We are made up of over 11,000 veterans who have been disabled with a spinal cord injury or dysfunction.

Tri-State Chapter is one of 34 chapters located throughout the United States also including Puerto Rico and Mexico. Our National Headquarters is now located on 18th St. in Washington, D.C. It is the first architectural barrier free building in the United States.

Our organization is dedicated to promote quality health care in V.A. Hospitals. We also render trained administrators in legislative, advocacy and veterans benefits.

A PARAPLEGIC IS AN INDIVIDUAL . . . Tri State Paralyzed Veterans of America is an organization formed by and for the most seriously disabled in the world. It is devoting its life and effort to every problem of each paraplegic regardless of race, creed or color. These problems are many, for a paraplegic has suffered a spinal cord injury resulting in paralysis: (1) inability to walk: (2) loss of control over internal functions: (3) loss of sensation below level of injury: (4) permanent confinement to a wheelchair.

Before going on with my statements, I would like to say, I am not here to be critical but hope to make you aware of existing problems. Let us not forget that the V.A. Administrators have done a commendable job considering the cut backs in the budget.

Some of the major complaints veterans have passed on to me are as follows:

1. There are too many doctors who are in training and not enough permanent ones. As a result, you get conflicting opinions and constant change.

2. Patients detained for hours should be subsidized for their meals. These meals were eliminated through a ruling from V.A. Administration.

3. There are not enough nurses on the floors where specialized care is needed.

4. There is a communication problem because of the many foreign doctors and a language barrier.

5. Not enough doctors are present during clinic hours.

We have always maintained a good relationship with the Hospital Administrator and his staff. I am sure some of these complaints can be remedied in the future.

The now existing Spinal Cord Injury V.A. Hospital in Cleveland is being investigated as to whether it will remain open. If the decision is to close the facility, it has been recommended that Pittsburgh be an alternate site. It would be beneficial to many veterans with spinal cord injuries in the Pittsburgh and surrounding areas.

In conclusion, in the past this committee has always recognized and compensated veterans for their service and sacrifice. Like this committee, P.V.A.'s only concern is getting the best health care for all veterans.

Mr. Chairman and Members of the Subcommittee, this concludes my statement and I will be glad to answer any questions that I can.

PREPARED STATEMENT OF WILLIAM DZURKO, NATIONAL SERVICE OFFICER, AMVETS, PITTSBURGH, PA.

Lady and Gentlemen of the committee, I am happy to have this opportunity to present an item of vital interest to the AMVETS of the Western District of Pennsylvania Library Service in the Veterans' Administration medical centers.

Ironically, in the Thursday evening issue dated April 21, 1983, a column titled "In Library Week, Readers Have Their Say."

Quoting Karen Miller, woman's page editor "I believe a library is as important to a community as, say, a hospital . . . to feed the brain, to escape from daily problems and for useful recreation. I believe we could not consider a community civilized without one," perhaps says it better than any thoughts I may have had on the subject.

At this time I want to add the following:

Our organization, the Western District of Pennsylvania and with the generous help of VFW Post 204 have become the "god-fathers" of library service in the six Veterans' Administration medical centers in our area; also the two State veterans homes are being provided with monies to help in their special projects.

Presently we hope to completely renovate the patients library in the Oakland Veterans' Administration Medical Center. This will include drapes, carpets, furniture, and needed book cases. The money involved is not large in comparison to your budgetary figures of the hospitals as a whole; however, to raise $7,000 is not exactly an easy task in the economic situation existing in Pittsburgh, Pennsylvania.

Basically, we want to bring to the attention of the committee, the importance of the library service to the long-term health care needs of the hospitalized veteran. To allocate to the Veterans' Administration medical center director's ample funds for the staffing of all health care divisions.

We in our area will continue to help in every way possible; but we want assurances that the special equipment being purchased will be available to the hospitalized veteran on a regular basis.

If the committee plans on touring either the University Drive VAMC or Aspinwall VAMC, I hope they will spend a few moments in either of the libraries. We are proud of the part the "god-fathers" are playing in their rehabilitation.

Our thanks to you this morning for this opportunity to present our thoughts on the library service as a long-term humanistic quality in our American society.

LOUIS A. JOHNSON VA MEDICAL CENTER
CLARKSBURG, WEST VIRGINIA

I. INTRODUCTION

During the week of June 28, 1982, a regularly scheduled visit was made to the Louis A. Johnson Veterans Administration Medical Center (VAMC) at Clarksburg, West Virginia to assess the quality, quantity, and timeliness of health care being provided to veteran patients.

Coordination: Notifications of the planned visit were sent to Mr. David J. Kilcogne, Medical Center Director; Messrs. Robert E. Vass, Sr., Department Adjutant, and Leo Criss, The American Legion VAVS Representative, The American Legion, Department of West Virginia; and Mr. Roland Savilla, Director, West Virginia Department of Veterans Affairs.

A meeting was arranged with Mr. Dick Conrad, Deputy Director, W.VA. Department of Veterans Affairs. He described a good working relationship with the VAMC and felt the medical center was responsive to veteran's needs.

Statistical information pertaining to personnel strength, patients on the rolls, and operating costs is attached.

Professional Affiliation: This VAMC has a limited affiliation for surgical residents with W.VA. University School of Medicine. Additional medical staff support is received through an affiliation with the United Hospital Center, Clarksburg, which provides Family Practice residents on a rotating basis. Mr. Robert LaFallette of The American Legion is the service organization representative on the Dean's Committee.

Hospital Accreditation: The Joint Commission on Accreditation of Hospitals conducted a survey on September 17-18, 1980, resulting in a full two-year accreditation. Another survey is anticipated to occur within a few months.

MISSION OF MEDICAL CENTER

This 216 bed primary, secondary and tertiary medical center provides acute medical, surgical and psychiatric inpatient care. Subspecialty medical programs include a medical, surgical, coronary care, and respiratory care intensive care unit, pulmonary function laboratory, and respiratory failure beds. Renal dialysis and Mental Hygiene facilities are also operational.

The 216 beds are designated as follows:

Medicine	93
Surgery	86
Psychiatry	37

For FY 82, cumulative through June, the VAMC occupancy rate was 82.9% with an average length of stay of 10.8 days and a turnover rate of 278.5%.

REGIONALIZATION

The Louis A. Johnson VAMC combines with VAMC at Altoona, Butler, Pittsburgh (Highland Drive and University Drive), and Erie, Pennsylvania to form the 5th Medical District of the Mid-Atlantic Region.

II. OBSERVATIONS

Adequacy of Funds and Personnel to Permit Satisfactory Performance of the Assigned Mission: The FY 82 budget has been adequate for this VAMC to perform its mission, and the FY 83 budget is expected to be adequate if the planned budget is received.

The Director's two main concerns were the recruitment of an orthopedic surgeon and the lack of space at this facility. Recruitment has been ongoing for a year for an orthopedic surgeon, but the lack of competitive salary and the location of this VAMC have rendered attempts at recruitment to be unsuccessful. At present, fifteen beds are categorized for an orthopedic caseload. Consideration is being given to making a request to Central Office for the redistribution of beds on a temporary basis from the Surgical Service to the Medicine Service until recruitment in surgery has reached full strength. Physical location of the beds would not be affected.

The major buildings at this VAMC were built in 1950 without facilities to serve outpatients and space to handle this function. The present area supporting this function is overtaxed and a Clinical Addition to meet the needs of Ambulatory Care, Pharmacy, and Laboratory. Supply Processing and Distribution (SPD) are planned for FY 84. Thirty-seven (37) beds for intermediate care, which is a projected need concluded by the Medical District Initiated Program Plan (MEDIPP) task force, are also included in this planned addition. Currently, there is no intermediate service and an increase of 140% of the number of veterans age 65 or older in this area is projected for 1990. Additionally, space needs for MAS, dietary and rehabilitation medicine, primarily physical therapy will be met as services relocate into the Clinical Addition.

Ward renovations are being planned for FY 83 and FY 84 to correct cited JCAH deficiencies by partitioning existing sixteen bed wards and renovating toilet rooms to provide patient privacy.

Professional Services: Recruitment has been ongoing for physicians. An orthopedic surgeon has been sought for a year, but salary and location do not make this VAMC very competitive for such a specialist. A second radiologist has been sought for nine months and a verbal acceptance has been received. There are two vacancies for internal medicine which have received commitments. However, a physician currently at the VAMC is expected to be leaving. The

Chief of Medicine wants to step down from administrative duties, but he will remain in the position until a replacement has been found. In this context, physician staffing was described as fluctuating. It was stated that there have been interviews for the positions, but it was difficult to find and get qualified candidates.

The University will not send residents without quality staff. At present, two surgical residents come from the W.VA. University School of Medicine. The relationship with the university was described as much improved.

Support services from laboratory, radiology, and nursing service were stated to be very good with the personnel shortage of another radiologist being reiterated. The medical center was described as bulging at the seams. The planned Clinical Addition will take care of space needs, and it was deemed a must to provide treatment as it should be given.

Associate Director: The Acting Associate Director indicated that services currently under her supervision were functioning well and staffing was generally adequate.

The appearance and condition of the medical center is well maintained. Equipment for the laundry is in the process of being upgraded. The Chief of Building Management stated that the ironer and folder were the original equipment and a request has been made for replacement. The washers and dryers are due for replacement in FY 84.

Security's staffing is at full complement. There is little turnover and pay is equivalent to that in the community. This is an area of relatively low crime incidence. Concurrent jurisdiction exists with the city and state, and a good working relationship exists.

ORIENTATION/PREPARATION OF INCOMING PERSONNEL

New federal employees are given a comprehensive orientation to familiarize them with their wages, benefits, opportunities and responsibilities as well as to familiarize them with the facility. This is initiated on the first day then completed in several phases.

ADMISSIONS, OUTPATIENT CLINIC AND AMBULATORY CARE

Space is the primary need in the Ambulatory Care and Outpatient Clinic areas. There is a need for more adequate space for exam rooms, waiting area and offices. There are eight examining rooms, and physicians for the clinics have difficulty finding a room. The present space has been used and converted to its maximum capacity. Only the planned Clinical Addition will alleviate the lack of space. Because the waiting area is inadequate, patients must use the hallway while waiting to be seen. Office space is limited. The physician assistant must walk through another office, or the emergency room, to get to his office.

It was noted that more first time veterans are being seen. Periodically, there have been extended waits for treatment because there are just too many people to be seen. However, this is often the result of walk-in patients, and there is no way to anticipate a busy day. Patients are given an explanation for their wait. As of May FY 82, 21,056 outpatient visits were made. Staffing was described as generally sufficient.

There are outpatient clinics for mental hygiene, surgery, medicine, and cardiology. Consultants are available for ENT each week and for dermatology each month. Cases for neurology, orthopedics, neurosurgery and some eye surgery are referred to VAMC Pittsburgh.

Medical Administration Service: This service was described as functioning well. Processing of Compensation and Pension Examinations, transcription, and summaries are done in a timely manner.

Staffing was described as adequate. There are two clerical vacancies and recruitment is ongoing. Ward clerks seem to represent the only turnover because of the low salary.

The telephone system is due for replacement which is expected by September.

BED SERVICES

Medical Service: There are 93 authorized medical beds. Through June in FY 82, occupancy rate was 101.2%, the turnover rate 347%, and the length of stay was 8.7 days. The Acting Chief of Medicine stated that there were three physician vacancies and two will be filled. A Chief of Medicine is also being sought as previously discussed.

Space is generally adequate. One ward has been remodeled and another planned for renovation to provide patient privacy. A new monitoring system for the intensive care unit has been approved and is expected in three months. A request for new ultra-sound equipment has also been approved. The exercise monitoring system used in conjunction with the treadmill has been having break downs and will need replacing.

Support services were deemed to be providing good support.

Surgical Service provides general surgery including abdominal, thoracic, vascular, and neck surgery. Open cardiac, eye, orthopedic, and neurosurgery are referred to VAMC Pittsburgh. In FY 81, 1,627 procedures were performed. As of June for FY 82, 1,232 procedures have been performed. It was noted that more major surgery is being done requiring more time.

There are three operating rooms, a cystoscopy room and a recovery room. This is generally adequate, and there will be renovation in the fall to make the surgical suite more sufficient.

There is a major vacancy for an orthopedic surgeon and ceiling for a third general surgeon. It was stated that bed occupancy would reach 80% with orthopedic cases. At present, the occupancy rate is 64% with an average length of stay of 15.4 days and a turnover rate of 197.5%. As discussed, a temporary redistribution of beds to the Medical Service, until staffing has reached full strength, is being considered. Physical location of the beds would not be affected. The Chief of Surgery commented that there is a need for competitive salaries.

Support services were considered adequate. Equipment is satisfactory.

The Chief of Surgery supervises rehabilitation medicine which consists of physical therapy and occupational therapy. At present the space in physical therapy is not adequate, but will be remedied by the domino effect of the 1984 Clinical Addition. Recruitment has been ongoing for an occupational therapist.

Psychiatry Service: This service has a thirty-seven bed opened unit. There is no specialized alcohol or drug treatment program but 40% of admissions are estimated to be substance abusers, primarily alcohol.

The professional staff is adequate and the nursing staff is sufficient for basic needs. Recreation is assigned to the Department of Psychiatry which consists of one person who covers the entire medical center.

Therapy is provided through a therapeutic milieu, individual and group therapy, and family therapy as needed. On the unit, patients progress through a series of four steps of increased responsibility and independence.

Alcoholics, including those with uncomplicated withdrawal, are merged with the patient population in the therapeutic community. The average length of stay for acute withdrawal is 3-4 days while patients are maintained, 7-10 days for psychiatric stabilization. There are psychotherapy groups and an alcohol information group. Alcoholics Anonymous provide information on the ward and have a weekly open meeting. A 28 day residential program is available at VAMC Pittsburgh (Highland Drive). An Alcohol Dependence Clinic is planned to be included as a new program as part of the Clinical Addition.

At present, limited aftercare is provided in the Mental Hygiene Clinic by a part-time psychiatrist who primarily handles patients' medication needs.

MEDICAL SUPPORTIVE SERVICES

Nursing service has sufficient staff which is operating at full ceiling. Recruitment is not a problem because salaries are competitive within the community and there are five nursing schools within the area. Turnover is virtually non-existent and this is illustrated by the lack of positions for new graduates.

The number of hours of care per patient was described as low compared to the private sector, but veterans are getting quality care. Morale was described as good.

It was noted that the discrepancy between Wage Grade (W.G.) salaries and GS salaries make jobs other than nursing more appealing. Dishwashers are capable of making a larger salary than nursing personnel providing direct patient care.

Pharmacy Service is located in a cramped area which does not allow efficient work flow. Four pharmacists operate in a close area, and space is needed to separate outpatient dispensing and the mail-out service. Furthermore, office space is meager and there is a lack of sufficient storage space. These deficiencies will be corrected by the relocation of the pharmacy in an enlarged area in the planned Clinical Addition.

Increased demand and inflation in the cost of drugs has affected budget requests. During the last two years there has been a 30% increase in the monthly number of prescriptions. During FY 81, 11,293 prescriptions were filled. Approximately 42% or 42,698 prescriptions were filled, approximately 42% or 42,698 of these were mailouts. Processing time for mailouts is within two days.

The turnaround time at the window varies with peak hours but averages 10-20 minutes.

Social Work Service has six social workers at the Master's Degree level providing consistent inpatient coverage, and daily rotating coverage by each worker of the outpatient/admission area. There has been an increased workload for nursing home placements. There are two social workers primarily in the field who cover 18 community nursing homes with 57 placements funded at present. There are about 20 veterans in the residential care program.

A shared cooperative agreement is in the process of being developed with community mental health agencies. This would provide a working agreement to provide transition of care of veterans from the community to inpatient care, and transition to outpatient care in the community after inpatient discharge. The community mental health centers provide a broad range of services and are often geographically closer to the veteran.

Radiology Service has a vacancy for another radiologist. Recruitment has been ongoing and a verbal acceptance has been received. Technician staffing was described as adequate.

It was stated that despite the need for an additional radiologist, the present work is done well and on time. Reports are getting done on the same day. The Chief of Radiology indicated that equipment in one of the diagnostic rooms needs replacement. Although it is functional, it is old, not up to date and having downtime. During the summation conference the Director stated he was not made aware of this, and the situation would be evaluated.

Laboratory Service has sufficient staffing with a low turnover rate. Equipment is precise and gets needed replacement and servicing. What is needed is additional space. Based on the workload that is performed, it is estimated that this service has less than half its needed space. At present, there is 4800 square feet of space and the anticipated space in the planned Clinical Addition is 10,200 square feet.

In the laboratory, equipment is stacked on counters next to each other with very little space in between. Temperature is less than adequately controlled and the air flow can't be changed. It is anticipated that a program will be developed to train medical technologists, but at present there is not space to accommodate students.

ANCILLARY SERVICES

Dietary Service provides primarily bed service. There is a dining area in the Psychiatric Service. The present tray trucks used to transport the food require repair, and are bulky and difficult to maneuver. There are plans for conversion to the Pellet System.

For the first two quarters of FY 82 the average number of daily rations has been 16,960 per quarter, the cost per ration was $3.10 and the average minutes per ration 46.9. Almost no convenience foods are used. The food sampled by this writer was delicious.

Staffing was stated to be generally adequate. A request will be made for one full-time health technician and a half-time clerk typist.

Freezer and refrigerator space is adequate. However, space is needed and would be received as a domino effect of the Clinical Addition. The kitchen area would remain in the same place but would be expanded. A new dishwasher is needed because the present one is in a congested area and needs a longer drying area. The nutrition clinic is a very cramped area with poor office space. There are three people sharing a small office area. This is planned for expansion.

Veterans Administration Voluntary Service (VAVS) has 30 organizations on the VAVS Advisory Committee. There are 210 regularly scheduled volunteers who contributed 13,000 hours during the second quarter of FY 82. Volunteers contributed to all the hospital services.

The American Legion Representative is Mr. Leo Criss and his Deputies are Mr. Olin Wharton and Mr. Olan Layman. Through May in FY 82, ten regularly scheduled volunteers contributed 820 hours. The American Legion Auxiliary Representative is Remont Taylor and her Deputy is Anne Hardman. Eleven regularly scheduled volunteers contributed 854 hours.

III. CONCLUSIONS

Based on personal observations and interviews with administrative personnel, medical center staff, and patients, it is concluded that quality patient care is being provided at the Louis A. Johnson VAMC.

Recruitment is ongoing for the needed physicians. The other primary need at this facility is to alleviate the lack of space. The three-floor Clinical Addition planned for FY 84 would provide the intermediate care beds to meet the needs and projected needs of veterans in this area. As discussed in this report, numerous services need expanded areas which would be provided directly or through a domino effect of the Clinical Addition. Pharmacy, Ambulatory Care and Outpatient Clinics, Laboratory and Radiology would be given the necessary space needed to provide quality patient care.

The present Ambulatory Care and Outpatient area is overtaxed with patients lining the hallways because of an inadequate waiting area. Pharmacy has an inefficient work area, meager office space, and insufficient storage space. Laboratory Service has less than half the needed space with equipment congested on the counter tops. The Clinical Addition would also provide an Alcohol Dependence Clinic. Dietary Service and physical therapy would also receive increased space through a domino effect of the construction.

The need for this Clinical Addition can be clearly discerned, and it is sorely needed.

IV. RECOMMENDATION

Background data and assessment on the following recommendation for this VAMC will be found in the observation and conclusion sections of this visitation report.

1. The American Legion recommends that approval for funding and construction of the Clinical Addition which includes intermediate care beds for FY 84, and also to include approval for the funding of increased ceiling for the additional personnel for these expanded programs.

VETERANS ADMINISTRATION MEDICAL CENTER VISIT STATISTICAL REPORT

LOCATION Clarksburg, WV DATE OF INFORMATION June 15,1982

MEDICAL CENTER DIRECTOR David J. Kilcoyne

Associate ~~ASSISTANT~~ MEDICAL CENTER DIRECTOR Richard H. Lawrence

CHIEF OF STAFF Carl P. Dahlen, M.D.

MEDICAL SCHOOL AFFILIATION West Virginia University

		CURRENT FY 1982	LAST FY 1981	
BED CAPACITY		216	216	
OPERATING BEDS		216	216	
AVERAGE DAILY				
INPATIENT CENSUS		178	178	
* OUTPATIENT VISIT (ACCUM.)		21,056	34,993	
WAITING LIST:				
SERVICE-CONNECTED	5/31/82 (	0	0)	9/30/81
NONSERVICE-CONNECTED	(	0	0)	

EXPLAIN THE REASON FOR THE WAITING LIST:

No one on the waiting list as of 9/30/81 and 5/31/82.

VA FORM 10-10 APPLICATIONS FOR MEDICAL CARE

RECEIVED LAST FISCAL YEAR	6,203	
NUMBER OF APPLICATIONS ACCEPTED	5,724	- 92.2%
NUMBER OF APPLICATIONS REJECTED	479	
APPLICATIONS FOR MEDICAL CARE RECEIVED THIS FISCAL YEAR	4,973	
NUMBER OF APPLICATIONS ACCEPTED	4,334	- 87.2%
NUMBER OF APPLICATIONS REJECTED	639	

STAFF

TOTAL MEDICAL CENTER PERSONNEL (FTE) 443.5 Medical Center
8.6 Canteen
CORE RATIO 1.78 2.0 Cemetery

STAFF PHYSICIANS (FTE) 17.5

CONSULTANTS ON THE ROLLS 70

ATTENDINGS ON THE ROLLS 4

RESIDENTS 4

MEDICAL STUDENTS 0

PHYSICIAN EXTENDERS 2

MAJOR PERSONNEL SHORTAGES

PHYSICIANS (FT BY SPECIALTY) 2 Internal Med. (1 Committe
1 Radiologist (Committed)
1 Orthopedic Surgeon

REGISTERED NURSES 0

LICENSED PRACTICAL NURSES 0

NURSING ASSISTANTS 0

OTHERS 0

SCHEDULED FOR ADMISSION (SERVICE-CONNECTED) 16

SCHEDULED FOR ADMISSION (NONSERVICE-CONNECTED) 30

SUMMARIES PENDING 56

TOTAL NUMBER OF REQUESTS FOR DISABILITY EVALUATION EXAMINATIONS (2507) ON HAND WHICH HAVE NOT BEEN COMPLETED AND RETURNED TO VA REGIONAL OFFICE 14

OPERATING BEDS IN NURSING HOME CARE UNITS 57 (CNHC Plan)

FUNDS

AVERAGE COST PER PATIENT DAY $170.87*

AVERAGE COST PER OUTPATIENT VISIT $ 56.65

AVERAGE COST PER NHCU DAY Not Applicable

AVERAGE COST PER PATIENT DAY IN COMMUNITY NURSING HOMES $38.57

MEDICAL CENTER BUDGET ALLOCATION (THIS FISCAL YEAR) $16,325,385 (FY-82)

MEDICAL CENTER BUDGET ALLOCATION (LAST FISCAL YEAR) $15,000,960 (FY-81)

*Data FY-81, latest 12 month period

BEST COPY AVAILABLE